Marion County Health Department
222 West Center St. Marion, OH 43302 Phone (740) 223-4162 Fax (740) 223-4225

APPLICATION FOR FLES PLAN REVIEW

Instructions:

1. Complete all applicable sections below
2. Sign and Date the application (original signature required)
3. Make check or money order for the appropriate fee payable to: Marion County Health Department
4. Return the application with the appropriate fee and enclose the following items:

_____ Site plans showing location of business in building, location of building on site including alleys and streets, and location of any outside equipment (dumpsters, wells, grease, traps, septic systems, etc).
_____ Floor plan (drawn to scale) showing entrances and exits, walls, plumbing, electrical services, mechanical ventilation, and location of all pieces of equipment.
_____ Menu (including seasonal and off-site banquet menus).
_____ Equipment list showing manufacturer and model numbers and referenced to location on the floor plan. Manufacturer Specification sheets (or cut sheets) are highly recommended as they will speed up the review process.
_____ Surface finishes

Type of Facility: _____Food Service Operation _____Retail Food Establishment

Type of Service (check all that apply):

_____Sit down meals _____Take-out _____Grocery/Retail _____Caterer _____Mobile _____Seasonal
Proposed hours of operation _____

Construction

_____New Total square feet of Facility _____
_____ Remodel Seating capacity _____
_____Addition/Expansion Anticipated starting date _____
_____Change of ownership Anticipated completion date _____

NAME OF OPERATION_____
OPERATION ADDRESS_____
NAME OF OWNER _____
OWNER ADDRESS _____
OWNER PHONE (S) _____
NAME OF AUTHORIZED REPRESENTATIVE _____
ADDRESS AUTHORIZED REPRESENTATIVE _____
AUTHORIZED REPRESENTATIVE PHONE(S) _____
Check the most appropriate capacity of authorized representative:
_____Contractor _____Owner _____Other (please indicate) _____
Please note that all correspondence will be sent to authorized representative

SIGNATURE OF AUTHORIZED REPRESENTATIVE:

_____DATE_____

FOR MARION COUNTY HEALTH DEPARTMENT USE ONLY
Date received _____ Sanitarian _____
Risk Level _____ Fee _____Receipt #_____