SANITATION BRANCH
79-1015 HAUKAPILA STREET, #115
KEALAKEKUA, HAWAII 96750
TELEPHONE NUMBER: (808) 322-1507 FAX: (808) 322-1511

STATE OF HAWAII
DEPARTMENT OF HEALTH
www.hawaii.gov/doh

# APPLICATION FOR PLAN REVIEW

(Please type or print in blue or black ink)

| **ESTABLISHMENT NAME (dba):** | **CHECK IF APPLICABLE:**<br>**( ) BLDG PERMIT APPLICATION SIGN-OFF REQUIRED**<br>**( ) PRELIMINARY LIQUOR DISPENSER APPROVAL ONLY** |
|---|---|

| **ESTABLISHMENT LOCATION ADDRESS:** | **TAX MAP KEY** | | | |
|---|---|---|---|---|
| STREET: | ZONE | SECTION | PLAT | PARCEL |
| CITY: ZIP CODE: | | | | |

**OWNER NAME (Corp., LLC, Partnership, Sole Owner, Other):**

| **CONTACT PERSON:** | **CONTACT PHONE NO.:** |
|---|---|

**I understand that approval of the submitted plan is contingent upon compliance with the requirements of Hawaii Administrative Rules, Title 11, Department of Health.**

**DATE** **SIGNATURE OF OWNER/AGENT**

**PHONE # OF OWNER/AGENT** **PRINT NAME** **TITLE**

**OWNER/AGENT MAILING ADDRESS:**

STREET:

CITY: STATE: ZIP CODE:

***(OFFICIAL USE ONLY)*** **FEE AMOUNT: (Circle One)** **Food New/Conversion $200** **Food Remodel $150**
**(NON REFUNDABLE)** **Swimming Pool $200** **N/A**

**Make check payable to: STATE OF HAWAII** **(BANK ACCOUNT NAME AND ADDRESS MUST BE ON CHECK)**

**Submit application and fee to:** **SANITATION BRANCH**
**79-1015 HAUKAPILA ST.**
**KEALAKEKUA, HI 96750**

THERE WILL BE A SERVICE FEE OF $25.00 FOR ANY CHECK DISHONORED BY THE BANK

***(FOR OFFICIAL USE ONLY)*** **COMMENTS (Continue on back):**

***I have been informed and received a copy of the deficiencies listed above that must be corrected before plan approval.***

*Signature of owner/agent* _____ *Print name*_____ *Date*_____

***SECTION BELOW FOR OFFICIAL DEPARTMENT OF HEALTH USE ONLY***

| Fee Paid | Date Paid | Method of Payment | Receipt No. | Received By |
|---|---|---|---|---|
| | | | | |

PLAN RECEIVED BY: NAME: _____ DATE: _____ REFERRED TO: _____

PLANS RECEIVED BY F & D: NAME: _____ DATE: _____ REFERRED TO: _____

REVIEWED BY: SIGNATURE: _____ DATE: _____ DATE SAN RECEIVED: _____

PLAN PICKED UP FOR REVISION: NAME: _____ DATE: _____ DATE RESUBMITTED: _____

PERSON NOTIFIED OF PLAN APPROVAL: NAME: _____ DATE: _____

APPROVED BY: _____ _____
Date Signature of Agent/Dept. of Health