MAUI DISTRICT ENVIRONMENTAL HEALTH OFFICE
54 HIGH STREET, ROOM 300
WAILUKU, HAWAII 96793
TELEPHONE: (808) 984-8230 FAX: (808) 984-8237

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:
( ) BLDG PERMIT APPLICATION SIGN-OFF REQUIRED
( ) PRELIMINARY LIQUOR DISPENSER APPROVAL ONLY

ESTABLISHMENT LOCATION ADDRESS:
STREET:
CITY: ZIP CODE:

TAX MAP KEY			
ZONE	SECTION	PLAT	PARCEL

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) (NON REFUNDABLE)** **Food New/Conversion $200** **Food Remodel $150** **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:
MAUI DISTRICT ENVIRONMENTAL HEALTH OFFICE
54 HIGH STREET, ROOM 300
WAILUKU, HI 96793

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: _____ REFERRED FOR REVIEW TO: _____ DATE: _____

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

REVISED PLAN RECEIVED BY: NAME: _____ DATE: _____

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

BUILDING PERMIT APPLICATION SIGNED BY: NAME: _____ DATE: _____

APPROVED BY: _____ _____ _____
Date Signature of Agent/Dept. of Health R.S. Lic. No.