



**FLORIDA DEPARTMENT OF HEALTH – BREVARD COUNTY**  
**Environmental Health Services**  
**2725 Judge Fran Jamieson Way, Suite A116**  
**Viera, Florida 32940-6605**  
**PHONE: 321/633-2100 FAX: 321/633-2151**  
**www.BrevardEH.com**

|                     |
|---------------------|
| For Office Use Only |
| Tracking Number     |
| Payment Information |

**GROUP CARE/SCHOOL INSPECTION REQUEST FORM**

Instructions: Do not leave any item blank. Enter "NA" for non-applicable items. Submit the completed inspection request form and fee (if applicable) to the address above. There is a \$35.00 fee for inspection requests for all facilities except schools. Checks should be payable to Brevard County Health Department. Payment with Visa and MasterCard are accepted via telephone at (321) 633-2100, option 4.

Facility Type (check only one):

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Adult Family Care Home*                        | <input type="checkbox"/> Assisted Living Facility*     | <input type="checkbox"/> Charter School                         |
| <input type="checkbox"/> Child Caring Agency*                           | <input type="checkbox"/> College/University            | <input type="checkbox"/> Crisis Stabilization Unit*             |
| <input type="checkbox"/> Homes for Special Services*                    | <input type="checkbox"/> Hospice*                      | <input type="checkbox"/> Intermediate Care Facility *           |
| <input type="checkbox"/> Private School                                 | <input type="checkbox"/> Public School                 | <input type="checkbox"/> Residential Treatment Facility (AHCA)* |
| <input type="checkbox"/> Short-Term Residential Treatment Center (DCF)* | <input type="checkbox"/> Transitional Living Facility* | <input type="checkbox"/> Vocational School                      |

\*Maximum number of residents/clients per licensing agency (or requested from licensing agency): \_\_\_\_\_

Assisted Living Facilities and other Residential Facilities listed in Section 381.006(16), *Florida Statutes* (F.S.), with a maximum capacity of 6 to 10 residents (excluding Adult Family Care Homes) are considered **Tier II Food Service Establishments**. Tier II Food Service Establishments initially licensed by the licensing agency or renovated on or after January 1, 2008 must complete a Food Establishment Plan Review Guide. Hospices or other Residential Facilities listed in Section 381.006(16), F.S., with a maximum capacity of 11 or more residents initially licensed by the licensing agency or renovated on or after January 1, 2008 are considered **Tier III Food Service Establishments** and must obtain a separate Food Sanitation Certificate.

Name of Establishment: \_\_\_\_\_

Physical Address of Establishment: \_\_\_\_\_  
Street City State Zip Code

Mailing Address if Different: \_\_\_\_\_  
P.O. Box or Street City State Zip Code

Telephone Number of Establishment: (\_\_\_\_) \_\_\_\_\_ E-mail Address: \_\_\_\_\_@\_\_\_\_\_

Contact Person: \_\_\_\_\_ Contact Telephone Number: (\_\_\_\_) \_\_\_\_\_

Name of Establishment Owner: \_\_\_\_\_

Mailing Address of Establishment Owner: \_\_\_\_\_  
P.O. Box or Street City State Zip Code

Telephone Number of Establishment Owner: (\_\_\_\_) \_\_\_\_\_

Operating Times: Monday Tuesday Wednesday Thursday Friday Saturday Sunday  
 24 hours  AM  AM  AM  AM  AM  AM  AM  
Opening Time: \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM  
Closing Time: \_\_\_\_\_  AM \_\_\_\_\_  AM \_\_\_\_\_  AM \_\_\_\_\_  AM \_\_\_\_\_  AM \_\_\_\_\_  AM  
\_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM \_\_\_\_\_  PM

Is this facility staffed and/or accessible during all hours of operation?  Yes  No

Water Source:  Onsite well  Public water supply Sewage Disposal:  Septic system  Public sewer  
(Facilities utilizing onsite wells and/or septic systems shall obtain all necessary approvals prior to receiving a satisfactory inspection result.)

The undersigned Representative hereby agrees to operate the facility described in this request in accordance with applicable state and local requirements. The information contained in this application, is true and correct.

\_\_\_\_\_  
Name of Representative (print or type)

\_\_\_\_\_  
Signature of Representative

\_\_\_\_\_  
Date