FLORIDA DEPARTMENT OF HEALTH – BREVARD COUNTY
Environmental Public Health Services
2725 Judge Fran Jamieson Way, Suite A116
Viera, Florida 32940-6605
PHONE: 321/633-2100 FAX: 321/690-6856
www.BrevardEH.com / brevardeh.facilities@flhealth.gov

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 annual 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):

- ☐ Adult Family Care Home*
- ☐ Assisted Living Facility*
- ☐ Charter School
- ☐ Child Caring Agency*
- ☐ Vocational School
- ☐ Crisis Stabilization Unit*
- ☐ Homes for Special Services*
- ☐ Hospice*
- ☐ Intermediate Care Facility *
- ☐ Private School
- ☐ Public School
- ☐ Residential Treatment Facility (AHCA)*
- ☐ Short-Term Residential Treatment Center (DCF)*
- ☐ Transitional Living Facility*
- ☐

*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	☐ PM
	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM
Closing Time: _____	☐ PM	☐ 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