

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.

Contact Person: Contact Telephone Number: () Name of Establishment Owner:	Facility Type (check only one):								
Homes for Special Services* Hospice* Intermediate Care Facility Private School Public School Residential Treatment Facility (AHCA)* Short-Term Residential Transitional Living Facility* Residential Treatment Facility (AHCA)* Short-Term Residential Transitional Living Facility* Residential Facility (AHCA)* Short-Term Residential Facilities and to the residential Facilities lated in Section 31 000(10). Florida Statutes (F.S.), with a maximum capacity of to 10 residents (excluding Adult Family Care Homes) are considered Ter If Food Service Establishments. Title If 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 lated in Section 381.006(10). Fis., with a maximum capacity of 1 to more residents initially licensed by the licensing agency or renovated on or after January 1, 2008 are considered Ter II Food Service Establishments and must obtain a separate Food Similation Certificate. Name of Establishment: Physical Address of Establishment: Street	☐ Adult Family Care Home*	☐ Assisted	Assisted Living Facility*			Charter School			
Private School	☐ Child Caring Agency*	☐ Vocation	Vocational School			Crisis Stabilization Unit*			
Short-Term Residential Treatment Center (DCF)* Maximum number of residents/clients per licensing agency (or requested from licensing agency):	☐ Homes for Special Services*	☐ Hospice	Hospice*			Intermediate Care Facility *			
Treatment Center (DCF)* **Maximum number of residents/clients per licensing agency (or requested from licensing agency): Assisted Living Facilities and other Residential Facilities listed in Section 391.000(16), Florida Startaes (F.S.), with a maximum capacity of 6 to 10 residents (excluding Adult Family Care Homes) are considered 'Tier Il Food Service Establishments: Intelligible Consideration of the C	☐ Private School	☐ Public S	Public School			Residential Treatment Facility (AHCA)*			
**Maximum number of residents/Clients per licensing agency (or requested from licensing agency): Adaid Family Care Homes) are considered Tire III Food Service Establishments are considered Tire III Food Service Establishments are considered Tire III Food Service Establishments. The II Food Service Establishment in Items (and the III Food Service Establishment) (and the III Food Service Establishment) (and the III Food Service Establishment) (and the III Food Service Establishment in III Food Service Establishment and must obtain a separate Food Sanitation Certificate. Name of Establishment as a separate Food Sanitation Certificate. Name of Establishment in III Food Service Establishment and must obtain a separate Food Sanitation Certificate. Name of Establishment: Physical Address of Establishment: Street City State Zip Code Mailing Address of Establishment: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: P.O. Box or Street City State Zip Code Contact Person: Contact Telephone Number: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Mailing Address o		☐ Transition	Transitional Living Facility*						
Adult Family Care Homes) are considered Tier II Food Service Establishments. Tier II Food Service Establishment III Food Service Establishment III Food Service Establishment III Food Service Establishment III Food Service III F		per licensing	g agency (or	requested fro	m lic	ensing agen	cy):		
Physical Address of Establishment: Street	Adult Family Care Homes) are considered Tier II Food on or after January 1, 2008 must complete a Food Esta maximum capacity of 11 or more residents initially I	I Service Establis ablishment Plan Ro icensed by the lice	hments. Tier II F eview Guide. Ho ensing agency or	Food Service Establi spices or other Resid	shme dentia	nts initially licensed I Facilities listed in	by the licensing Section 381.006	g agency or renovated 6(16), F.S., with a	
Street City State Zip Code Mailing Address if Different: P.O. Box or Street City State Zip Code P.O. Box or Street City State Zip Code Contact Person: Contact Person: Contact Telephone Number: () Name of Establishment Owner: P.O. Box or Street City State Zip Code P.O. Box or Street City State Zip Code Telephone Number 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 Q4 hours AM	Name of Establishment:								
Mailing Address if Different: P.O. Box or Street City State Zip Code Contact Person: Contact Telephone Number: Mailing Address of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Departing Times: Monday Mo	Physical Address of Establishment:						State	Zin Codo	
P.O. Box or Street City State Zip Code Telephone Number of Establishment: ()	Mailing Address if Different:				ιy		State	Zip Code	
Contact Person:					ty		State	Zip Code	
Name of Establishment Owner: Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code	Telephone Number of Establishment: ()			E-mail Address:			@		
Mailing Address of Establishment Owner: P.O. Box or Street City State Zip Code Telephone Number of Establishment Owner: Operating Times: Monday AM AM AM AM Opening Time: PM	Contact Person:			Contact Tel	epho	one Number:	()		
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	Name of Establishment Owner:								
Telephone Number of Establishment Owner: (Mailing Address of Establishment Own	ner:							
Operating Times: Monday Tuesday Wednesday Thursday Friday Saturday Sunday 24 hours	·	P.O.	Box or Street		Ci	ty	State	Zip Code	
□ 24 hours □ AM □ A	Telephone Number of Establishment (Owner: ()						
Opening Time:	· • — —								
Closing Time:									
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)									
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)		_			_		⊔ ғ	РМ ЦРМ	
(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)	Is this facility staffed and/or accessible	during all ho	ours of opera	ition? ⊔ Yes	L	J No			
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	Name of Representative (print or type	e)							
	Signature of Representative					-		Date:	