APPLICATION FOR PLAN REVIEW

Saint Paul - Ramsey County Department of Public Health - *Environmental Health Section*
2785 White Bear Avenue, Suite #350, Maplewood, MN 55109-1320
Phone: 651-266-1199 Fax: 651-266-1177

Name of New or Remodeled Establishment:		
Address of New or Remodeled Establishment:	**City:**	
Name of Owner (use corporation name if applicable)**:**		**Attention:**
Mailing Address:	**City & ZIP:**	**Telephone:** ( )

Name of Person Submitting Plans:_____ **Title:** _____

Business Name & Address: _____

E-mail address: _____ **Telephone: (_____)** _____

Others to Receive Correspondence Regarding This Project:

Name: _____ **Title:** _____ **Email Address:** _____

Name: _____ **Title:** _____ **Email Address:** _____

Name: _____ **Title:** _____ **Email Address:** _____

Type of Project (Check One):

____ New Construction ____ Remodeling of Existing Licensed Facility ____ Facility or Equipment Review

Type of Establishment (Check One):

☐ Bakery	☐ Coffee Shop	☐ Grocery Store	☐ Restaurant	☐ Theatre
☐ Bar	☐ Continental Breakfast	☐ Ice Cream Store	☐ Restaurant w/Bar	☐ Youth Camp
☐ Cafeteria	☐ Convenience Store	☐ Lodging Facility	☐ School	☐ Other:
☐ Catering	☐ Day Care	☐ Mfg Home Park	☐ Snack stand	_____
☐ Concession Stand	☐ Deli	☐ Meat Market	☐ Take-Out food w/o Seating	

The following information must be submitted with this application:

- One complete set of building plans, including room finish schedule, equipment layout, plumbing, & mechanical plans.
- Food service equipment specifications and installation requirements, including manufacturer name & model number. (Specification sheets on compact disc are acceptable and encouraged when possible)
- Complete menu of all foods and beverages to be prepared and/or served; and
- Plan review fee (check payable to "Ramsey County") $_____

Plans cannot be reviewed until all information is received.

Certification Statement:

I hereby request that the plans and specifications for the establishment named above be promptly reviewed. I hereby state all information required to complete the plan review are attached. I understand the information stated on the plans and specifications to be an accurate description of the final, completed establishment. I agree any changes in construction from the approved plans must be submitted for further review and approval by the Department of Public Health. I agree to notify the Department of Public Health at least 15 days prior to opening this establishment for business.

_____	_____	_____
Signature	Printed Name	Date

FOR OFFICE USE ONLY:

Date Received: _____ / _____ / _____ License Category: _____ Plan Review Fee: $_____

Sanitarian / Date: _____ / _____ Fee Paid: $ _____ Check # _____ Receipt #_____

Account # _____ Invoice # PHCS-_____

Date Payment Posted: _____ Deposit ID #_____ Entered by: _____