

**Plan Review Application for a
Mobile Food Service Unit**

Operation Information

(Please Print)

❖ *Service Request*

Operation Name (Doing Business As): _____
 Mobile Unit Operating Location: Single Site Multiple Sites/Route (Include all locations with plan submittal.)
 Single Site Address: _____ City: _____ Zip: _____
 Scope (Briefly describe operation/menu style): _____
 Former Name: _____ Unit Type: Cart Vehicle Trailer Movable Building
 Required Information: WA License Plate # _____ VIN # _____ WA L & I Sticker # _____

❖ *Plan Check N.O.S. # 2***Plan Review Submittal Fee (Make checks payable to: "SKCDPH"). The Plan Review Fee is nonrefundable.**

New Operation (\$972 + \$243/hr after 4 hours) (S602)
 Mobile changes (\$486 + \$243/hr after 2 hours) (S611)
 Resubmitted Plan (\$243/hr) (S605)

Ownership Information❖ *Requestor*

Are you the new owner? Yes No
 Name(s): First _____ M.I. _____ Last _____
 Business Name (Corp, LLC, etc): _____
 Mailing Address: _____ City: _____ State: _____ Zip: _____
 Phone No.'s _____
 Fax (Optional): _____ Email (Optional): _____

Applicant Information (If different from owner)❖ *Plan Check*

Contact Person (Applicant or Agent) Name(s): _____
 First _____ M.I. _____ Last _____
 Business Name (Corp, LLC, etc): _____
 Mailing Address: _____ City: _____
 State: _____ Zip: _____
 Phone No.'s _____
 Fax (Optional): _____ Email (Optional): _____

Commissary Information❖ *Property Information*

Business Name: _____
 Location/Address: _____ City: _____
 State: _____ Zip: _____
 Commissary Owner/Contact Person: _____ Phone No.: _____
 Fax (Optional): _____ Email (Optional): _____ Sewage: Sewer Septic System

Restroom Information (Must provide restroom availability letter for each stop that lasts longer than 1 hour)❖ *SR Info Add Comment Sec.*

Business Name: _____
 Location/Address: _____ City: _____ State: _____ Zip: _____
 Business Owner/Contact Person: _____ Phone No.: _____
 Fax (Optional): _____ Email (Optional): _____ Sewage: Sewer Septic System

❖ **Office Use Only**

Date Submitted: _____ Risk Classification: _____ Service Request SR#: _____
 Facility Account FA#: _____ Account Receivable AR#: _____ Invoice IN#: _____
 Variance SR#: _____ Permit Record PR#: _____ DPD/DDES #: _____
 Approval Date: _____ Review Time: _____ Reviewer: _____ Mobile Sticker # _____
 Notes: _____

DISTRICT HEALTH CENTERS

DOWNTOWN
401 5th Ave, 11th
Floor Seattle, WA
98104
206-263-9566

EASTGATE
14350 S.E. Eastgate
Way Bellevue, WA
98007
206-477-8050