



MULTNOMAH COUNTY OREGON
ENVIRONMENTAL HEALTH
3653 SE 34TH AVENUE
PORTLAND, OR 97202
(503) 988-3400; FAX (503) 988-5844
www.mchealthinspect.org

RESTAURANT PLAN REVIEW APPLICATION

Facility Name:

Facility Location Address (number, street, city, state, zip code):

Owner Name [individual(s)]:

Corporation Name:

Owner Address (number, street, city, state, zip code):

Owner Telephone Number:

Owner Cell Phone Number:

Owner FAX Number:

Contact for Plan Review:

Contact Address (number, street, city, state, zip code):

Contact Telephone Number:

Contact Cell Phone Number:

Contact FAX Number:

Plan review approval should be sent to:

Owner

Contact

Approximate completion date:

TYPE OF CONSTRUCTION

New Construction

Remodel

Consultation

Food service will be Open during construction/remodel
 Closed

Water Supply:

Sewage Disposal:

Sewer

Subsurface

Application is hereby made for plan review of the above facility in compliance with the provisions of the Oregon Administrative Rules, OAR 333-161-0000 requires that plans be submitted to the assistant director (authorized representative) and Environmental Health Specialist (Registered Sanitarian) for review and commented on before construction, remodeling, or conversion is begun.

Payment of the \$_____ plan review fee is hereby made with the understanding that OAR 333-161-0000 requires that plans be submitted for review when a food service facility is constructed or extensively remodeled. All construction must conform to OAR 333-150-0000 through 333-156-0330 as printed in the "Food Sanitarian Rules" published by the Oregon Department of Human Services. And OAR 333-161-0010 requires that the food service facility be inspected prior to the start of operation to determine compliance with the reviewed plans and specifications and with the requirements of these rules. All information contained in this record is public.

* Please refer to fee schedule or call our office for information regarding Plan Review fee.

Make Check Payable To:

Multnomah County Environmental Health

Applicant's Signature

Date

NOTE: THE FEE MUST ACCOMPANY THIS APPLICATION

Fee Received:

Date:

By:

Check #:

Cash: