



COUNTY OF LOS ANGELES ♦ DEPARTMENT OF PUBLIC HEALTH
ENVIRONMENTAL HEALTH - PLAN CHECK PROGRAM

5050 Commerce Drive, Baldwin Park, CA 91706-1423
(626) 430-5560 www.publichealth.lacounty.gov/eh



RETAIL PLAN CHECK APPLICATION

3 sets of plans are required. Incomplete applications will not be processed. For correct fees, please refer to the [Plan Check Fee Schedule](#).

PERSON SUBMITTING: TITLE: PHONE:

EMAIL:

FOOD MARKET (Supermarkets - see below)
Prepackaged Foods Only Yes No (No Drink Dispensing, Bulk Foods, Cut Produce)

Potentially Hazardous Foods Yes No

25 - 50 Sq. Ft. \$
 51 - 1,999 Sq. Ft. \$
 2,000 - 5,999 Sq. Ft. \$
 6,000 - 19,999 Sq. Ft. \$
 20,000 Sq. Ft. or more \$

RESTAURANT (Each department, based on Sq. Ft.)
 500 Sq. Ft. or less \$
 501 - 1,999 Sq. Ft. \$
 2,000 - 3,999 Sq. Ft. \$
 4,000 - 9,999 Sq. Ft. \$
 10,000 Sq. Ft. or more \$

REMOTE STORAGE
 0 - 500 Sq. Ft. \$
 501 - 4,999 Sq. Ft. \$
 5,000 - 9,999 Sq. Ft. \$
 10,000 Sq. Ft. or more \$

SUPERMARKET (Each department, based on Sq. Ft.)
 Main Food Market \$
 Meat Market \$
 Bakery \$
 Deli \$

REMODELING OF CURRENTLY OPEN FOOD FACILITY WITH VALID PERMIT/LICENSE

****PROVIDE COPY OF HEALTH PERMIT/LICENSE****
 LESS than 300 Sq. Ft. \$

Mark appropriate business classification box to the left For remodels exceeding 300 Sq. Ft., select appropriate fee (at left) based on the size of the facility. Describe the scope of remodeling in space below:

MISCELLANEOUS (i.e., additional plan reviews or inspections, site or equipment evaluations):
Reason for additional fees incurred: \$

ANSWER THE FOLLOWING QUESTIONS

New food facility Yes No

New owner of business Yes No

Approximate date business closed:

New building construction after 1/1/04 Yes No

Re - usable tableware Yes No

Plans for on - site consumption of alcoholic beverages, either now or future Yes No

Grand Total: \$
NAME

COMPLETE ADDRESS

PHONE

Food Business:
Business Owner/Operator:
Architect/Contractor:

OWNER REPRESENTATIVE DECLARATION: I understand the amount of fee paid is **NON-REFUNDABLE** and the application is **NON-TRANSFERABLE**. The fee paid is based on my declaration of the business classification indicated above. If this declaration is incorrect, I understand that the plans will not be reviewed until the correct fee is paid. I also understand that plans shall be reviewed within 20 (regular) or 10 (expedited) working days after receipt of payment and the **REVIEWED PLANS (WHETHER APPROVED OR NOT) ARE VALID FOR ONE YEAR. FINALLY, I UNDERSTAND PLANS MUST BE APPROVED PRIOR TO COMMENCING CONSTRUCTION OR INSTALLING ANY EQUIPMENT, AND IT IS A MISDEMEANOR VIOLATION TO BEGIN OPERATION WITHOUT A FINAL INSPECTION, APPROVAL, AND VALID HEALTH PERMIT/LICENSE.**

SIGNATURE: _____ DATE:

OFFICE USE ONLY

CONTACT OFFICE

PAYMENT
Fee paid: _____
Receipt no.: _____
Check no, or cash: _____
Date paid: ____/____/____
Cashier's initials: _____

PLAN CHECK NUMBER
SR _____