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

WHOLESALE 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 WHOLESALE

- ◯ FOOD MARKET $ ____
- ◯ FOOD MARKET COMPLEX $ ____

FOOD SALVAGER

- ◯ FOOD SALVAGER $ ____

WHOLESALE FOOD PROCESSING

- ◯ 0-1,999 $ ____
- ◯ 2,000-5,999 $ ____
- ◯ 6,000 or more $ ____

FOOD WAREHOUSE

- ◯ 0 - 500 Sq. Ft. $ ____
- ◯ 501 - 4,999 Sq. Ft. $ ____
- ◯ 5,000 - 9,999 Sq. Ft. $ ____
- ◯ 10,000 Sq. Ft. or more $ ____

SHARED KITCHEN COMPLEX

- ◯ 0 - 9,999 Sq. Ft. $ ____
- ◯ 10,000 or more $ ____

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 ____

Maximum # male employees per shift ____

Maximum # female employees per shift ____

	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. FINALY, 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	PLAN CHECK NUMBER
	Fee paid: ____ Receipt no.: ____ Check no, or cash: ____ Date paid: ____/____/____ Cashier's initials: ____	SR____