KANKAKEE COUNTY HEALTH DEPARTMENT
DIVISION OF ENVIRONMENTAL HEALTH
2390 W. STATION, KANKAKEE, IL 60901
VOICE: (815) 802-9410 FAX: (815) 802-9411

OFFICE USE ONLY
Amt Rcvd. _____
Cash____ Check #_____
Card Type____App#_____
Date Rcvd.____ Rcvd By____
Appvd By_____Mailed____

FOOD SERVICE FACILITY PLAN REVIEW

I/we hereby submit plans and specifications to construct, remodel or convert a Food Service Establishment or as a new owner in Kankakee County.

Name of Establishment _____ Home Work Mobile ( )_____

Street Address _____City_____State_____Zip_____

Licensee/Owner _____ Home Work Mobile ( ) _____

Corporate Owner _____Home Work Mobile ( ) _____

Mailing Address_____City_____State_____Zip_____

Operator/Manager_____ Home Work Mobile ( ) _____

Email Address _____ Fax Number _____

Are Certified Food Handler(s) on staff? ___Yes ___No If so, how many? _____

In an emergency, how can we contact you? Home Work Mobile Email Fax (Please Circle)

Choose one of the following:

[ ] New Construction
[ ] Change of Ownership (no remodeling)
[ ] Remodel of existing permitted establishment (same owner)
[ ] Remodel of existing non-permitted establishment
[ ] Remodel of existing permitted establishment (new owner)

A full set of plans, list of equipment to be used in the facility (refrigeration units, freezers, steam tables, etc.), including method of equipment installation and plan review fee ARE TO BE SUBMITTED WITH THIS FORM

ANY CHANGES IN PLANS OR ON THIS FORM MUST RECEIVE ADVANCED APPROVAL

Plans to be returned Yes____ No_____

The appropriate fee of this plan review is reflected in Section II on Page 2 of this packet.

Signature of owner or authorized agent _____ Date_____

PAYMENT INFORMATION
Please return this completed, signed and dated application and stipulated fee in the form of a check ( ), cashier's check ( ) or money order ( ) made payable to the **KANKAKEE COUNTY HEALTH DEPT.** Credit card instructions are below.

When you provide a check as payment, you authorize us to use information from your check to process a one-time Electronic Funds Transfer (EFT) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment and you will not receive your check back from your financial institution. If your payment is returned unpaid, you authorize the collection of your payment plus a return fee of $25.00 by EFT or drafts drawn from your account.

If you would like to pay be credit card, please fill out the following information:
( ) Please charge my credit card for the amount as indicated above per the Annual Fee Schedule
Card Type (Please Circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS
CARD NUMBER:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ CVS#: __ __ __EXP. DATE: __ __/__ __

SIGNATURE: _____ DATE: _____

II. CLASSIFICATION OF FACILITY

TYPE OF FOOD ESTABLISHMENT

_____	Restaurant	_____	Gas Station (Retail)	_____	Day Care
_____	Caterer	_____	Gas Station (Food Service)	_____	Hospital
_____	Tavern	_____	Mobile Unit	_____	Long Term Care Facility
_____	School/Milk Only	_____	School/Satellite Kitchen	_____	School/Full Kitchen
_____	Grocery (sq. ft. of building _____)	_____	Grocery w/deli (Sq. ft. of building _____)		
_____	Other _____				

Business Hours _____ to _____ Days Closed _____

Type of Menu _____
(Copy of menu must be submitted)

Buffet Set-Up (banquet, salad bars, luncheons, etc.) Yes___ No___
Catering? Yes___ No___ Delivery Service? Yes___ No___
Seating Capacity _____
Public Restroom Provided Yes___ No___ Men's___ Women's ___

To determine the category in which your facility will be classified as, please check all lines that apply to your food preparation activities. This will reflect your plan review fee. If construction has begun or if the establishment is expecting to open in less than a month, an additional $100.00 priority fee is to be paid in addition to the regular plan review fee.

HIGH RISK FOOD ACTIVITIES ($500.00)

_____ Complex preparation including cooking, cooling, and reheating for hot holding involving time/temperature control for safety food;
_____ Processes requiring hot and cold holding of time/temperature control for safety foods;
_____ Conducting specialized processes as described in 3-502 of the FDA Food Code; or
_____ Serving a highly susceptible population as defined in 1-201.10 of the FDA Food Code.

MEDIUM RISK FOOD ACTIVITIES ($400.00)

_____ Most products are prepared or cooked and served immediately
_____ May involve hot and cold holding of time/temperature control for safety foods after preparation or cooking; or
_____ As approved by the regulatory authority, preparation of time/ temperature control for safety foods requiring cooking, cooling, and reheating for hot holding limited to 2 or fewer same items or processes with approved procedures.

LOW RISK FOOD ACTIVITIES ($250.00)

_____ Heating only commercially processed time/temperature control for safety foods for immediate service with no hot holding or assembly
_____ Only time/temperature control for safety foods commercially prepackaged in an approved processing plant are available or served at the facility
_____ Only limited preparation of non-time/temperature control for safety foods and beverages, such as snack foods and carbonated beverages, occurs at the facility; or
_____ Only beverages (alcoholic or non-alcoholic) and garnishes that are non-time/temperature control for safety are served at the facility

_____ **CHANGE OF OWNERSHIP NO REMODELING ($200.00)**