Public Health
Seattle & King County

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 ($919.20 + $229.80/hr after 4 hours) (S602)
☐Mobile changes ($459.60+ $229.80/hr after 2 hours) (S611)
☐Resubmitted Plan ($229.80 2/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:_____

PLAN REVIEW APPLICATION SUBMITTAL

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