



**FORT BEND COUNTY HEALTH DEPARTMENT
PLAN REVIEW INFORMATION SHEET**
(Must be completed in its entirety)

Establishment Name: _____

Establishment Address: _____ City _____

Owner: _____ Phone _____

Total Square Footage of the Facility: _____

Date Plans Submitted: _____

Architect: _____ Phone # _____

Contact Person: _____ Phone # _____

E-mail Address: _____ Fax # _____

Construction Contractor: _____ Phone # _____

Superintendent: _____ Phone # _____

E-mail Address: _____ Fax # _____

Plan Review Contact Person _____ Phone # _____

Fax # _____ E-mail Address: _____

Projected Construction Start Date: _____ * No construction is allowed until the
"Authorization to Construct" is issued.

The following information must be received before a plan review will be performed:

Checklist:

_____ Application: Completed and signed

_____ Floor Plans: Scaled drawings including equipment layout, plumbing, mechanical, lighting,
and finish schedule.

_____ Menu

_____ Description of Operation: Completed and signed.

_____ Equipment Specifications Sheets

_____ Risk Assessment Form: Completed and signed

_____ Plan Review Information Sheet

_____ Color Samples