DEPARTMENT OF HEALTH
Ground Floor, County Office Building, 7 Court Street, Belmont, New York 14813
Phone: (585)268-9250 Fax: (585)268-9264

PLAN REVIEW CHECKLIST

Start Date of Construction:

Anticipated Completion Date:

Instructions: *Complete all sections of this Plan Review Checklist (Print or Type)*
If any section of the checklist does not apply to your establishment, please mark "N/A" in box

Name of Establishment:	Phone:	E-Mail:
Establishment Address:	City/Town:	Zip Code:
Owner's Name (Corporation Name):	Phone:	Fax:
Owner Mailing Address:	City/Town:	Zip Code:
Emergency Contact Person:	Title:	Phone:

In order to obtain plan approval, floor plans of the subject establishment must be submitted. These plans are to be drawn to scale and should include all rooms in the establishment as well as the location of food service equipment.

Please complete the ***Plan Review Checklist*** on the next pages, mark "N/A" after a question if it does not pertain to your establishment. You are **REQUIRED** to fill out the list of equipment including, manufacturers name and model number for each item. You **MUST** submit a tentative menu for review by this office. This information must be provided prior to construction beginning per New York State Sanitary Code.

Business Type: (Please Check One)

☐	Restaurant w/o bar	# of seats =
☐	Restaurant w/bar	# of seats =
☐	Frozen Dessert	Square footage =
☐	Mobile Food Unit w/Commissary	# of vehicles/units =
☐	Brew Pub	# of seats =
☐	Caterer	Square footage =

Plan Review Fee $----at cost based on invoice from reviewing engineer
*Please make check payable to ***Allegany County Health Department****

I certify that the above and below information contained in this plan review checklist is true, accurate, and complete: _____
Signature/Title

_____ _____
DATE **PRINT NAME**

WATER SUPPLY

A. Source of Water Supply: Municipal ☐ Private Well ☐

If ***PRIVATE***, please note that the system must be inspected and approved prior to issuance of a health permit. If a new source is being developed you MUST consult with our office prior to beginning. Please contact our office to discuss (585) 268-9266

B. If Municipal, name Water Authority/District_____

C. Water heater capacity _____gallons.

D. Thermometer setting of water heater _____ degrees F.

E. Backflow Prevention Device Required (check one) YES ☐ NO ☐
You should check with your water supplier if serviced by a municipal/public water supply to determine whether a device is required

If YES, is this a new device being installed? (check one)
YES ☐ NO ☐

If YES, licensed engineered plans/specifications and backflow prevention application must be submitted with this plan review checklist!

If you have an existing backflow prevention device has it been approved and tested at least annually? (check one) YES ☐ NO ☐

SEWAGE DISPOSAL

A. Type of Sewage Disposal: Municipal ☐ Private System ☐
B. If answer to A. is Private, please contact our office to check on approved plans

C. If Municipal, please provide name of your Sewer Authority/District _____

D. If ***new*** construction, please include a copy of sewage approval either from our office (if we designed) or a licensed engineer that is licensed in the State of New York

PLEASE NOTE** that no Health Permits will be issued without an approved water source **AND** an approved method of sewage disposal per New York State Sanitary Code

SERVICE – RESTROOMS

A. Type of Food Service: Sit Down ☐ Take-out ☐
B. How many seats will be provided for the public? Seats _____

C. Will public restrooms be provided for each sex? Yes ☐ No ☐

D. Are separate employee restrooms provided? Yes ☐ No ☐
E. Do restroom facilities open directly into any room in which food, drink, and/or utensils are handled or stored? Yes ☐ No ☐

F. Is adequate ventilation provided for all restrooms provided through screened windows or by exhaust fans? Yes ☐ No ☐
G. Are restroom doors self-closing? Yes ☐ No ☐
H. Specify total number of fixtures in restrooms.
   1. Toilets _____
   2. Urinals _____
   3. Lavatory Hand sinks _____

HAND WASHING FACILITIES

A. Are hand washing facilities provided in each food preparation area and restroom facility? Yes ☐ No ☐

B. Are the hand washing sinks provided with hot and cold running water? Yes ☐ No ☐

C. Are the hand washing sinks provided with mixing faucets? (Faucets with one handle) Yes ☐ No ☐

UTENSILS AND EQUIPMENT

A. Submit a list of all equipment with manufacturer's name and model number of each item. All equipment must conform to current National Sanitation Foundation Standards (NSF). Give description of construction for custom-built equipment. Location of all equipment is to be indicated on drawings.

B. Will equipment be installed according to NSF Guidelines? Yes ☐ No ☐

C. Explain where pots/pans be washed? _____

UTENSIL WASHING EQUIPMENT

A. Type of utensils used: Single Service ☐ Multi-Use ☐

B. Method of Sanitizing: 3 Compartment Sink ☐ Dishwasher ☐ Other ☐

C. Dishwasher: Manufacturer _____ Model # _____

D. Method of Dishwasher Sanitization: Hot Water ☐ Chemical ☐

E. Booster Heater: Manufacturer _____ Model # _____

UTENSIL STORAGE

A. Is sufficient space provided for utensil storage? (spatulas, tongs, dishes, flatware, etc.) Yes ☐ No ☐

B. Is the ice cream dipper well provided with running water?
Yes ☐ No ☐

C. Does the ice cream dipper well have an indirect waste line?
Yes ☐ No ☐

VENTILATION

A. Type of ventilation system: Canopy ☐ Ventilator (updraft) ☐ Other ☐

B. Size of hood: Length _____ Width _____ Overhang _____

C. Distance from floor to bottom of hood (canopy only) _____

D. Volume of air to be exhausted _____ CFM

E. Number, design, and size of filters: No._____ Design _____ Size ____

F. Length and diameter of ducts: Length _____ Diameter _____

G. Exit for exhausted air: Roof ☐ Side of Building ☐ Other ☐

REFRIGERATION

A. Are adequate NSF standard refrigeration facilities provided?
Yes ☐ No ☐

B. Will thermometer(s) (accurate to ± 3 degrees F.) be provided for all refrigeration units? Yes ☐ No ☐

C. Will potentially hazardous foods (meats, dairy, poultry, fish, etc.), be refrigerated while on display? Yes ☐ No ☐

HOT HOLDING

A. Will facilities be provided for hot holding of potentially hazardous foods?
Yes ☐ No ☐

If NO, EXPLAIN:_____

B. If yes, are these facilities NSF approved? Yes ☐ No ☐

C. Metal-stemmed (probe stem) dial type thermometers must be provided to monitor food temperatures that read from 0-220 degree Fahrenheit!

SNEEZE GUARDS

A. Will a buffet or salad bar be a part of your operation?
Yes ☐ No ☐

B. Will sneeze guards be provided on all serving lines or salad bars?
Yes ☐ No ☐

C. Do sneeze guards adequately protect food from contamination?
Yes ☐ No ☐

D. Provide a scale drawing of all areas requiring sneeze guards. Include dimensions, height from floor, and location of food.

REFUSE DISPOSAL

A. Where will the refuse storage area be located: _____

B. Circle type and indicate capacity of containers to be used:
Dumpsters ☐ Cans ☐ Compactor ☐

C. Will equipment and facilities be provided for cleaning of waste containers?
Yes ☐ No ☐

CLEANING FACILITIES

A. Is a mop sink provided for filling and emptying mop buckets, etc.?
Yes ☐ No ☐

DRESSING ROOM

A. Is outside ventilation provided through exhaust ducts or screened windows?
Yes ☐ No ☐

B. Is adequate closet or locker space provided for employee's personal belongings?
Yes ☐ No ☐

LIGHTING

A. Please note that 40 ft. candles of light are required in all food preparation areas!

B. Types of bulbs: Fluorescent ☐ Incandescent ☐

C. Are lights protected in the food handling and utensil washing areas? (guarded, recessed, boxed, etc.) Yes ☐ No ☐

DOOR WINDOWS

A. Are all exterior openings screened or otherwise protected against the entrance of vermin. Yes ☐ No ☐

PLUMBING/CERTIFICATE OF OCCUPANCY

All plumbing is recommended to be checked by a licensed plumber and meet satisfactory standards set forth in the New York State Uniform Building Code. Your establishment must obtain a certificate of occupancy prior to issuance of a Health Permit from the local Code Enforcement Officer (CEO).

_____ _____ _____

Signature of C.E.O. PRINT NAME DATE

ALLEGANY COUNTY HEALTH DEPARTMENT INSPECTION INFORMATION			
SHOP LOCATION: TELEPHONE:			
	FLOORS	WALLS	CEILING
FOOD PREPARATION AREA	MATERIAL (vinyl, ceramic, tile): Coved-Base Molding:	MATERIAL: FINISH: COLOR:	MATERIAL: FINISH: COLOR:
UTENSIL WASHING AREA	MATERIAL: Coved-Base Molding (vinyl, ceramic):	MATERIAL: FINISH: COLOR:	MATERIAL: FINISH: COLOR:
STORAGE AREAS	MATERIAL: Coved-Base Molding:	MATERIAL: FINISH: COLOR:	MATERIAL: FINISH: COLOR:
RESTROOM (S)	MATERIAL: Coved-Base Molding:	MATERIAL: FINISH: COLOR:	MATERIAL: FINISH: COLOR:

LIGHTING SCHEDULE

	Ft. Candles	Arrangement	Cleaning	Shielding
PREP. & WASHING				
STORAGE AREA				
RESTROOMS				

EQUIPMENT IDENTIFICATION SCHEDULE

SHOP LOCATION:

ITEM NO.	DESCRIPTION	MANUFACTURER	MODEL #	QUANITY