MOBILE FOOD FACILITY (MFF) PLAN CHECK APPLICATION

ENVIRONMENTAL HEALTH - PLAN CHECK PROGRAM
5050 Commerce Drive, Baldwin Park, CA 91706-1423
www.publichealth.lacounty.gov/eh
(626) 430-5560

2 sets of plans for vehicles are required. Incomplete applications will not be processed.

Plan Owner: _____ Designee/Contact: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ E-mail address: _____

BUSINESS CLASSIFICATION:	APPLICATION FEE
MFF:	$
Commissary:	$
Mobile Support Unit:	$
Remodel of a permitted MFF:	$
MFF Evaluation:	$
Miscellaneous:	$

Briefly describe the remodel in the space below:

_____

IMPORTANT NOTES

- Your plans will not be reviewed until the plan check fee is paid.
- The plans will be reviewed within 20 (regular) or 10 (expedited) working days upon receipt of your plan check fee, application and plans.
- The plan checker will contact you after the plans are reviewed. Plan reviews will be mailed unless otherwise requested. (i.e. Fax or E-mail)
- The initial plan check fee entitles you to a maximum of two plan reviews. A charge of $167 will be assessed for the third review, and a charge of $167 for all subsequent plan reviews.
- The initial plan check fee entitles you to a maximum of two field inspections. A charge of $167 will be assessed for the third inspection, and a charge of $167 for all subsequent inspections.
- Plans must be approved before beginning construction or installing any equipment. You must have your APPROVED set of plans at the job site. All required agency approvals must be submitted at the time of final inspection.
- If you have any questions, please contact your plan checker at (626) 430-5560.
- Plans will only be released to the plan owner.

	NAME	COMPLETE ADDRESS	PHONE
MFF:			
Business Owner/Operator:			
Vehicle Manufacturer:			

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 TO BEGIN OPERATION WITHOUT A FINAL INSPECTION, APPROVAL, AND VALID HEALTH PERMIT/LICENSE.**

SIGNATURE:_____ DATE: _____ Print Form

OFFICE USE ONLY

CONTACT OFFICE	PAYMENT	PLAN CHECK NUMBER
	Fee paid: _____ Receipt no.:_____ Check no, or cash: _____ Date paid: _____/_____/_____ Cashier's initials: _____	SR_____