FOR OFFICE USE ONLY	
Check Amount	
Check Number	
Approval Date	

State of Delaware
Office of Health Facilities Licensing and Certification

APPLICATION FOR BLUEPRINT REVIEW

I. Identifying Information OHFLC Project Code _____

Provider Legal Name _____

Doing Business As (DBA) _____

Facility Address _____

City _____ State DE Zip Code _____

Facility Phone _____

Owner _____ Phone _____ Email _____

Architect _____ Phone _____ Email _____

Main Facility Project Contact

Name _____ Phone _____ Email _____

Relationship to Owner _____

II. Regulatory Details ☐ Licensed ☐ Certified ☐ Both

Scope of Project

- ☐ New facility
- ☐ New area or service in existing facility
- ☐ Renovation in existing facility
- ☐ Single-phased
- ☐ Multi-phased

Square Feet of new construction or renovation: _____ Fee $ _____

Does this project require a Certificate of Public Review(CPR) review? ☐ Yes ☐ No
(If yes, attach a copy of CPR approval letter)

The fee structure for plan review for the facilities that fall under a Hospital Licensure shall be as follows:

New Construction	
Square Footage	**Fee**
10,000 or less	$250
10,001-20,000	$300
20,001-30,000	$350
30,001-40,000	$400
40,001-50,000	$450
50,001-above	$500
Renovations	
Square Footage	**Fee**
5,000 or less	$100
5,001-10,000	$150
10,001-15,000	$200
15,001-20,000	$250
20,001-25,000	$300
25,001-30,000	$350
30,001-35,000	$400
35,001-40,000	$450
40,001-above	$500

Checks or Money Orders should be made payable to the State of Delaware

It must include the Project Code BP#

III. Submit the following as a **single submission**:

- ☐ A. Attach proof of Fire Marshal plan review and approval.
- ☐ B. Attach proof of Office of Engineering plan review and approval.
- ☐ C. Blueprint Submission Memorandum (Using Current FGI Guidelines)
- ☐ D. Set of blueprints (PDF only)
- ☐ E. Check (for the facilities that fall under a Hospital Licensure)

V. If surgical facility or hospital operating rooms, complete the following:

# of Prep Beds _____

# of Recovery Beds _____

# of Procedure Rooms _____

# of Endoscopy Procedure Rooms _____

# of Operating Rooms _____

Total Number of Operating Rooms _____

Name of the person completing the form _____ Title _____

Email _____ Phone _____

Signature _____ Date _____

Check or money order should be made payable to **State of Delaware**

It must include the Project Code BP#

Please type and return the application with the fee to
Office of Health Facilities Licensing and Certification
263 Chapman Road, Suite 200
Newark, DE 19702

For Office Use Only

Application Reviewed & Approved By _____ Date _____

Rev. 01-30-2023