

FOR OFFICE USE ONLY	
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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Health Care Quality
Office of Health Facilities Licensing & Certification

APPLICATION FOR BLUEPRINT REVIEW

I. Identifying Information:

OHFLC Project Code _____

Facility Name _____

Facility Address _____

Address 1

Address 2

City

State

Zip Code

Owner _____

Email

Phone Number

Fax

Architect _____

Email

Phone Number

Fax

Main Facility Project Contact _____

Name

Relationship to Owner _____

Email

Phone Number

Fax

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 \$ _____

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

- III. Attach proof of Fire Marshal plan review and approval.
- IV. Attach proof of Office of Engineering plan review and approval.
- 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	_____

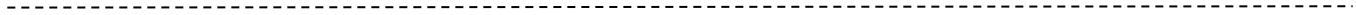
Signature of person completing this application and date

Date
Signature

Reviewed and returned by OHFLC:

Date

Signature



Accepted by OHFLC:

Date

Signature