FOR OFFICE USE ONLY
Check Amount: _____
Check Number: _____

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