

## Construction Review Application Packet

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### Important Information:

Incomplete applications will be returned without review.

### In order to process your request:

**Return completed application, fee, two copies of the plans and specifications to:**

Department of Health  
Construction Review Services  
111 Israel Rd SE MS 47852  
Tumwater, WA 98501

## Fee Information:

Every application must be submitted with the appropriate fee based on the following services. Construction review fees are outlined in [WAC 246-314-990](#) or contact our office for assistance. Incomplete applications will be returned without review.

**Plan Review** – If this application is for Plan Review, the project is either:

- **New Construction or Alterations/Renovation:** Fees are based on the initial project cost, which includes all costs directly associated with the project.
- **Building Conversion:** Fees are based on the value of existing construction (per sf). A conversion is an existing non-licensed facility wishing to be licensed.

**Installation of Finishes Only Review** – \$120 flat fee. These projects require no physical modifications and include the installation of finishes such as carpet, vinyl wall covering, wallpaper, exterior siding, or paneling applied to an existing surface as the exposed surface.

**Technical Assistance** - \$410 flat fee.

**Mobile Unit Review** - \$470 flat fee for first submission and \$285 for each additional submission. A separate application is required for the review of the mobile unit, and the site installation of that mobile unit.

**Change of Approved Use Review** – \$120 flat fee. Change of use is a change in the function of a room that does not alter the physical elements and construction is not required to meet the regulations for the intended use (i.e. patient room to office). The facility must be currently licensed.



Construction Review Services  
111 Israel Rd SE  
PO Box 47852  
Tumwater, WA 98501  
360.236.2944  
<http://www.doh.wa.gov/crs>

## Construction Review Application Checklist and Instructions

- Please indicate type of application. New or amended.

### Section #1: Demographic Information:

- Legal Owner/Operator Name:** Enter the owner's name as it appears on the UBI/ Master Business License.
- Check One:**  
Please check your **legal owner/operator** business structure type according to your Washington State Master Business License.
- Legal Owner Mailing Address:** Enter the owner's complete mailing address.
- Phone and Fax Numbers:** Enter the owner's phone and fax number.
- Uniform Business Identifier Number (UBI #):** Enter your Washington State UBI #. All Washington State businesses must have UBI #'s. city, county, and state government departments also have UBI #'s.
- Federal ID Number (FEIN#):** Enter your FEIN, if the business has been issued one.
- Email and Web Address:** Enter the owner's email and Web addresses, if applicable.
- Facility Name:** Enter the facility's name as advertised on signs or Web site. The facility name should match the name given to the Department in previous applications, and should be the same as indicated on the facility license (if currently licensed).
- Site Address:** Enter the facility's physical street location of the location where the construction or renovation will occur including city, state, zip and county.
- Phone and Fax Numbers:** Enter the facility's phone and fax number.
- Facility Mailing Address:** Enter the facility's mailing address, if different than physical address.

### Section #2: Site Information:

- Type of Facility:** Check the most appropriate type of facility. A separate application and set of documents shall be submitted for projects containing multiple facility types. The documents should clearly identify which areas are to be included under which facility type.

## Construction Review Application Checklist and Instructions (continued)

- Project Title:** The project title will identify the work to be performed, will remain the same throughout the project, and should be a limited number of characters. All submissions shall be identified by the facility name and project title.

Project title examples: Proposed boarding home, new CT room, west wing remodel, floor 3.

- Tax Parcel #:** Enter the property tax parcel number.
- Building Permit Jurisdiction:** Enter the local building jurisdiction for this project. CRS works closely with the local building jurisdiction. In some cases there may be two local agencies that have jurisdiction. Please provide both jurisdictions.
- Number of Beds Current:** Enter current number of beds.
- Number of Added Beds:** Enter number of beds added.
- Number of Beds Removed:** Enter number of beds removed.
- Number of Beds Current:** Enter current number of beds.
- Estimated Date of Occupancy:** Enter the estimated date in which the space will be occupied for its intended use.

### Section #3: Project Cost Estimate:

- Project Cost Estimate Section:** Enter the estimated cost for new construction and alterations/renovations on the appropriate lines. Project cost shall include the cost of all project-related costs except taxes; architectural or engineering fees; and land acquisition fees. Certain equipment costs may be waived from being included in the construction cost upon the approval of CRS. A request shall be made to CRS in writing before the approval can be granted.

A [fee calculator](#) is available for your use.

You do not use this section for any flat fees.

- Enter the construction type, applicable edition code, primary IBC occupancy group, mixed use, NFPA primary occupancy group, NFPA mixed use.**
- Sprinkler System Type:** Check the fire sprinkler system type.
- Fire Alarm System:** Check yes or no or complete.
- Delayed Egress Control:** Check yes or no.

### Section #4: Project Description:

- Project Description:** Enter a brief project description. For renovations, include the location within the facility where the renovation will occur (e.g., third floor, west wing, etc.).

## Construction Review Application Checklist and Instructions (continued)

### Section #5: Key Individuals:

- Facility Administrator:** Enter the administrator name, phone number, and email address if available.
- Facility Contact:** Enter the contact name, phone number and email address, if available. To save time, CRS will often email review comments to the project team members.
- Design Professional in Responsible Charge:** Enter the firms name, UBI #, registered design professional name, address, phone, fax, and email address.
- Consultant Information:** Enter all the consultant information. The consultant is the architect or engineer that will be assisting you with your project. We strongly recommend the services of an architect or engineer be used as early in the project as possible. Licensing regulations require most facilities drawings to be stamped and signed by an architect or engineer registered in the state of Washington.

- Signature:

Signature of legal owner or authorized representative.

Date signed.

Print name and title of legal owner or authorized representative.



Washington State Department of

Health

Construction Review Services  
111 Israel Rd SE  
PO Box 47852  
Tumwater, WA 98501  
360.236.2944  
<http://www.doh.wa.gov/crs>

Date Stamp Here

Check One	
<input type="checkbox"/>	Plan Review
<input type="checkbox"/>	Finish only
<input type="checkbox"/>	Technical Assistance
<input type="checkbox"/>	Mobile Units 1st Submission
<input type="checkbox"/>	Mobile Units Additional Submission
<input type="checkbox"/>	Change of approval use only
<b>Note: Additional fees may be assessed.</b>	

Revenue: 0597633200

### Construction Review Application

Type of application – Please check one:  New  Amended

#### 1. Demographic Information

Legal Owner/Operator Name \_\_\_\_\_

#### Check One

- |                                                        |                                                 |                                                   |
|--------------------------------------------------------|-------------------------------------------------|---------------------------------------------------|
| <input type="checkbox"/> Association                   | <input type="checkbox"/> Limited Partnership    | <input type="checkbox"/> Sole Proprietor          |
| <input type="checkbox"/> Corporation                   | <input type="checkbox"/> Municipality (City)    | <input type="checkbox"/> State Government Agency  |
| <input type="checkbox"/> Federal Government Agency     | <input type="checkbox"/> Municipality (County)  | <input type="checkbox"/> Tribal Government Agency |
| <input type="checkbox"/> Limited Liability Company     | <input type="checkbox"/> Non-Profit Corporation | <input type="checkbox"/> Trust                    |
| <input type="checkbox"/> Limited Liability Partnership | <input type="checkbox"/> Partnership            |                                                   |

#### Mailing Address

City	State	Zip	County	Country
Phone #	Fax #	Cell #		
Email Address				
UBI # (Secretary of State #)			Federal Tax ID (FEIN) #	

#### Web Address

#### Facility Name

#### Site Address

City	State	Zip	County
Facility Contact Phone #		Fax #	

#### For Office Use Only

Check No. \_\_\_\_\_ Amount \_\_\_\_\_ CRS Project No \_\_\_\_\_

## 2. Site Information

**Type of Facility/License:**

- |                                                                 |                                                  |                                                         |
|-----------------------------------------------------------------|--------------------------------------------------|---------------------------------------------------------|
| <input type="checkbox"/> Hospital                               | <input type="checkbox"/> Correctional Facility   | <input type="checkbox"/> Nursing Home                   |
| <input type="checkbox"/> Alcohol & Chemical Dependency Hospital | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Psychiatric Hospital           |
| <input type="checkbox"/> Ambulatory Surgery Center              | <input type="checkbox"/> Food Service            | <input type="checkbox"/> Residential Treatment Facility |
| <input type="checkbox"/> Boarding Home                          | <input type="checkbox"/> Hospice Care Center     | <input type="checkbox"/> State Facility                 |
| <input type="checkbox"/> Child Birth Center                     | <input type="checkbox"/> Mobile Unit             |                                                         |

Project Title		Tax Parcel #		Building Permit Jurisdiction	
Number of beds current	Number of added beds	Number of beds removed	Estimated date of occupancy		

### 3. Project Cost Estimate (This is not for flat fees listed on page 1 of this application) [Fee Calculator](#)

New Construction Cost Estimate	\$
Alterations/Renovation	\$
Building Conversion	\$
Fixed installed equipment	\$
Equipment Cost Adjustment *	\$ (            )
Construction Cost Estimate Total	\$
Fee from table ( <a href="#">WAC 246-314-990</a> )	\$
Architect Reduction *	Less            %
Previously Licensed Reduction *	Less            %
<b>Adjusted Fee</b>	<b>\$</b>

\* Must be pre-approved by DOH Construction Review Services. Attach copy of approval

Construction Type	Applicable Edition Code	Primary IBC Occupancy Group
Mixed Use	NFPA Primary Occupancy Group	NFPA Mixed Use
Sprinkler System Type <input type="checkbox"/> 13 <input type="checkbox"/> 13R <input type="checkbox"/> 13D <input type="checkbox"/> Other	Fire Alarm System <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Complete	Delayed Egress Control

## 4. Project Description

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## 5. Project Key Individuals

Facility Administrator <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	Phone #	Email Address
Facility Contact <input type="checkbox"/> Mr. <input type="checkbox"/> Ms.	Phone #	Email Address

Mailing Address	City	State	Zip
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### Design Professional in Responsible Charge

Firm Name	UBI #
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Registered Design Professional  Mr.  Ms.

Mailing Address	City	State	Zip
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Phone#	Fax #	Email Address
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### Consultant Information

Firm Name	UBI #
-----------	-------

Registered Design Professional  Mr.  Ms.

Mailing Address	City	State	Zip
-----------------	------	-------	-----

Phone#	Fax #	Email Address
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### Consultant Information

Firm Name	UBI #
-----------	-------

Registered Design Professional  Mr.  Ms.

Mailing Address	City	State	Zip
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Phone#	Fax #	Email Address
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### Consultant Information

Firm Name	UBI #
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Registered Design Professional  Mr.  Ms.

Mailing Address	City	State	Zip
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Phone#	Fax #	Email Address
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### Signature

I certify that I have received, read, understood, and agree to comply with state law and rule. I also certify that the information herein submitted is true to the best of my knowledge and belief.

\_\_\_\_\_  
Signature of Owner/Authorized Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Print Title