



Washington State Department of
Health
 Construction Review Services
 310 Israel Rd SE
 PO Box 47852
 Tumwater, WA 98501
 360.236.2944
<http://www.doh.wa.gov/crs>

Construction Review Application Packet

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Important Information:

Plan Review – If this application is for Plan Review, the review is defined in WAC 246-314-010(5).

Interior Finish – If this application is for interior finish, the review fee for interior finish projects is \$120. Projects that require no construction or physical modifications to the facility qualify as interior finish projects. Identical materials being installed to replace existing CRS approved materials do not need to be submitted for review.

Change of Approved Use – If this application is for change of approved use, the construction review fee will be \$120. Change of use projects only apply to projects where construction is not required to meet the regulations for the intended use, and the facility is currently licensed by DOH/DSHS (e.g., patient room to office – submission of supporting documents still required).

Technical Assistance – If this application is for Technical Assistance, the construction review fee will be \$410

Incomplete applications will be returned without review.

In order to process your request:

Return completed application, fee, two copies of the plans, and one copy of the functional program to:

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

Fee Information:

For review fee table, please see WAC 246-314-990 for the definition of project cost.



Washington State Department of

Health

Construction Review Services

310 Israel Rd SE

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Tumwater, WA 98501

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Construction Review Application Checklist and Instructions

- Please indicate type of application. New or amended.
- Legal Owner/Operator Name: Enter the owner's name as it appears on the UBI/Master Business License.

Section #1: Demographic Information:

- 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).
- Physical 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.
- 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.

Construction Review Application Checklist and Instructions (continued)

- 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 need to use this area for any flat fees which are listed on the top of the first page of the application. These fees include: Finish only, technical assistance, mobile units, and change of approval use only.

- 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.
- Smoke Control System Required:** Check yes or no if this is required.
- Compartmentation Required:** Check yes or no.
- 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.).

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 of legal owner or authorized representative.

Print title of legal owner or authorized representative.

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Date
Stamp
Here

Fees – Check One	
Plan Review	See project cost estimate
Finish only	\$120.00
Technical Assistance*.....	410.00
Mobile Units	470.00
Change of approved use only	120.00
Payable in US Funds	
*NOTE: Additional fees may be assessed.	

Revenue: 0597633200

Construction Review Application

Type of application – Please check one: New Amended

1. Demographic Information

Legal Owner/Operator Name _____

Check One

- | | | |
|-------------------------------|------------------------|--------------------------|
| Association | Limited Partnership | Sole Proprietor |
| Corporation | Municipality (City) | State Government Agency |
| Federal Government Agency | Municipality (County) | Tribal Government Agency |
| Limited Liability Company | Non-Profit Corporation | Trust |
| Limited Liability Partnership | Partnership | |

Mailing Address

City	State	Zip	County	Country
------	-------	-----	--------	---------

Phone #	Fax #	Cell #
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Email Address

UBI # (Secretary of State #)	Federal Tax ID (FEIN) #
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Web Address

Facility Name

Site Address

City	State	Zip	County
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Facility Contact Phone #	Fax #
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For Office Use Only

Check No. _____ Amount _____ CRS Project No. _____

2. Site Information

Type of Facility:

Acute Care Hospital	Correctional Facility	Nursing Home
Alcohol & Chemical Dependency Hospital	End Stage Renal Disease	Psychiatric Hospital
Ambulatory Surgery Center	Food Service	Residential Treatment Facility
Boarding Home	Hospice Care Center	State Facility
Child Birth Center	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	\$
Fixed installed equipment	\$
Equipment Cost Adjustment *	\$ ()
Construction Cost Estimate Total	\$
Fee from table (WAC 246-314-990)	\$
Architect Reduction *	Less %
Previously Licensed Reduction *	Less %
Adjusted Fee	\$

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

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

4. Project Description

5. Project Key Individuals

Administrator	Mr.	Ms.	Phone #	Email Address
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Facility Contact

Name			
Contact Name			
Mr. Ms.			
Mailing Address	City	State	Zip
Phone #	Fax #	Email Address	

Design Professional in Responsible Charge

Firm Name		UBI #	
Contact Name			
Mr. Ms.			
Mailing Address	City	State	Zip
Phone #	Fax #	Email Address	

Consultant Information

Firm Name		UBI #	
Consultant Contact			
Mr. Ms.			
Mailing Address	City	State	Zip
Phone #	Fax #	Email Address	

Consultant Information

Firm Name		UBI #	
Consultant Contact			
Mr. Ms.			
Mailing Address	City	State	Zip
Phone #	Fax #	Email Address	

Consultant Information

Firm Name		UBI #	
Consultant Contact			
Mr. Ms.			
Mailing Address	City	State	Zip
Phone #	Fax #	Email Address	

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