pennsylvania
DEPARTMENT OF HEALTH
DIVISION OF SAFETY INSPECTION

PLAN REVIEW CHECKLIST

Submitter Information

Company Name: _____ Today's Date: _____

Contact Person: _____ Telephone No: _____

Email: _____

Street Address: _____

City _____ State: _____ Zip: _____

Facility Information

Facility Name: _____

ID No: _____ Component No: _____

Street Address: _____

City: _____ State: _____ Zip: _____

County: _____

Type of Review

☐ Electronic Appointment ☐ Electronic Mail

Date of Appointment:

Plan Reviewer: Choose a Reviewer

Submissions must be uploaded 24 hours prior to your appointment.

Type of Submission

☐ Preliminary Review ☐ Final Review

Submission Category

☐ New Facility
☐ ESRD CMS Exemption
☐ Alteration/Renovation to Existing Facility
☐ Addition to Existing Facility
☐ Revision to Previously Approved Plans
Are revisions properly clouded? ☐ Yes ☐ No
☐ Sprinkler Drawings to Previously Approved Plans
☐ Stand Alone Sprinkler Project

Revisions and Sprinkler Drawings to Previously Approved Plans:

List Dept. of Health Drawing Index Number(s) of previously approved plans associated with this project:

_____

Skilled Nursing Facility

If this project is for the addition of a Special Locking Arrangements, has an exception been granted by the Division of Nursing Care Facilities? ☐ Yes ☐ No

ESRD Facility

If you are seeking the CMS Exemption, did you include a completed attestation form?

☐ Yes ☐ No

Documentation

Check required documents when applicable.

☐ Narrative on Facility Letterhead
☐ Sprinkler Calculations
☐ Architect/Engineer Seals

Estimated Capital Expenditure $ _____