APPLICATION FOR RESIDENTIAL CARE FACILITY

Applicant Name: ____________________________________________________________

Phone Number: ____________________________________________________________

Facility will be licensed thru:

[ ] Department of Social Services    (Water & Septic Inspection Only)
[ ] Smoky Mountain Mental Health    (Full Sanitation Inspection Required)
[ ] Other

Date inspection needs to be completed by: ______________________

Directions ____________________________________________________________________________________________
____________________________________________________________________________________________________

Type of water supply:  
[ ] City
[ ] Community well
[ ] Private: 
[ ] Drilled well

Sewage Disposal:  
[ ] City
[ ] On-site

If septic system is on-site, NAME of ORIGINAL OWNER and DATE OF INSTALLATION

Original Owner: ___________________ Date: __________________

Signature of applicant: ___________________ Date: __________________

FOR OFFICIAL USE ONLY

Application received: (date)______________(initials)____________ Type of Water Supply:________

Date Assigned: ___________________ Assigned to EHS: __________________________

Copy of applicable rules mailed _____ or given _____ date ______________________

Comments: ____________________________________________________________________________________________
____________________________________________________________________________________________________

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