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:____________________________________________________________________________________________
____________________________________________________________________________________________________