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| **DEPARTMENT OF HEALTH SERVICES**Division of Quality AssuranceF-62333 (02/2024) | **STATE OF WISCONSIN**Wis. Stat. §§ 50.02(2)(b)1, 50.025, 50.36(2)(a), and 50.90(3m)Page 1 of 8 |
| **PLAN APPROVAL APPLICATION****For Health Care Facilities Regulated by the****Department of Health Services (DHS) Division of Quality Assurance (DQA)** |
| **DQA CONTACT INFORMATION** |
| If you have questions or concerns regarding this application or the plan approval process, call or email the DQA Office of Plan Review and Inspection (OPRI). If you would like to know more about the health care construction plan review process, visit the OPRI [*Construction/Remodeling Plan Review for Health Care Facilities Health Care*](http://www.dhs.wisconsin.gov/regulations/plan-review/forms.htm) webpages.Phone: 414-227-4085 (Milwaukee)Email: dhsdqaplanreview@dhs.wisconsin.gov |
| **SUBMISSION OF MATERIALS AND FEES** |
| **Materials to be Submitted** |
| [ ]  | **Application** – Original completed DQA form F-62333, *Plan Approval Application* – Mail to the Plan Intake Coordinator. |
| [ ]  | **Fee** that reflects the current scope of work – Mail payment to the Plan Intake Coordinator. |
| [ ]  | **Digital application** - completed DQA form F-62333, *Plan Approval Application* – Send PDF by email. |
| [ ]  | **Digital set of plans** with the **drawing index sheet** bearing the required signature and seals – Send PDF by email.  |
| [ ]  | **Digital set** **of specifications and calculations** bearing the required signature and seals – Send PDF by email. |
| [ ]  | [***Permission to Start Construction for Footings and Foundation***](https://www.dhs.wisconsin.gov/library/F-62457.htm)*(*DQA form F-62457) **–** If the *Plan Approval Application* involves a hospital, hospice, or free-standing emergency department and a request for permission to start *is to be submitted,* the permission to start request and fees must be submitted **WITH** the Plan Approval Application.  |
| **Fees** |
| [ ]  | A separate fee payment and application must be submitted for each separate address/project/license type. |
| [ ]  | Make check payable to the **Division of Quality Assurance** or **DQA**. |
| **Submission**  |
| [ ]  | **ALL MAILED MATERIALS MUST BE SUBMITTED TO THE ADDRESS LISTED BELOW.** Sending materials to other DQA regional offices will delay the plan review process.DHS / Division of Quality AssuranceATTN: Plan Intake Coordinator819 N. 6th St. / Rm. 609BMilwaukee, WI 53203-1606 |
| [ ]  | **ALL DIGITAL MATERIALS MUST BE SUBMITTED TO THE EMAIL ADDRESS LISTED BELOW.** Sending materials to other DQA email addresses will delay the plan review process.dhsdqaplanreview@dhs.wisconsin.gov |
| **Plan review submittals will be assigned to a DQA plan reviewer with a unique 10-digit DQA plan review number ONLY after all required materials and fees are received and found to be acceptable.****Fees are not refundable.** |
| **PLAN APPROVAL APPLICATION CONTENTS** |
| 1. **PROJECT INFORMATION (Page 3)**

Section 1 requests general facility information and a brief project description for the following types of facilities: |
| * Hospital
* Hospice
* Long Term Care (LTC) (Nursing Home)
* Community-Based Residential Facility (CBRF)
* Community Substance Use Residential Service (DHS75)
* Free-Standing Emergency Department
 | * Ambulatory Surgery Center (ASC) Attached
* End-Stage Renal Dialysis (ESRD) Attached
* Residential Care Apartment Complex (RCAC) Attached
* Medical Office Building Attached
* Other Attached (as specified)
 |
| 1. **PLAN SUBMITTAL REQUEST PROJECT TYPES (Page 3)**

Section 2 requests information regarding the type of projects, type of plan review(s) requested, bed number, and CBRF licensing. **Type of Project(s)** |
| * New Building
* Alteration
* New Addition
* New License
 | * Use Change
* License Change
* Other Project (as specified)
 |

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| **Type of Plan Review(s) Requested** |
| * Building
* HVAC
* Fire Protection Systems – Fire Alarm System, Fire Sprinkler System
* Building Systems – Essential Electrical System, Emergency Lighting, Kitchen Hood System, Nurse Call System, Special Locking System.
* Component Plans – Structural Components (truss, precast members, or footing and foundation)
* Miscellaneous – Other Plan Review, Onsite Plan Review
* Plan Approval Extension
* Revisions to Previously Approved Plan
 |
| 1. **PLAN REVIEW CONTACT PERSON (Page 3) –** Information provided in this section identifies the contact person who will receive the DHS-assigned reference number, instructions about online verification via email, and who will be the main point of contact throughout the plan review and approval process.
2. **FEE TABLES (Page 4) –** This section provides several tables for determining fees based on total gross floor area and project dollar amount. The fee calculation worksheet in Section 5 includes other types of fees.
3. **FEE CALCULATION (Pages 5-6) –** This section provides a detailed worksheet used to calculate the fees.

**6. DESIGNER INFORMATION AND ATTESTATION (Page 7)****7. SUPERVISING PROFESSIONAL INFORMATION AND ATTESTATION (Page 7)****8. COMPONENT DESIGNER INFORMATION AND ATTESTATION (Page 8)****9. OWNER/ENTITY INFORMATION AND ATTESTATION (Page 8)** |
|  |
| Contact the Department of Safety and Professional Services (DSPS) at <http://dsps.wi.gov/plan-review> for individual submittal requirements for all of the following --- **plumbing systems, elevators or escalators, mechanical refrigeration, boiler and pressure vessels, and tank storage of 5,000 gallons or more of flammable or combustible liquids.** |
| **NOTE: State plan review and approval are separate from local permits. Check with the local municipality and county for their requirements.** |
| **PLAN APPROVAL APPLICATION****For Health Care Facilities Regulated by the** **Department of Health Services (DHS) Division of Quality Assurance (DQA)** |
| **DQA USE ONLY** | Project No.      | Plan No.      | Reviewer      |
| Check Provider      | Check No.      | Transaction No.      | Amount      |
| **1. PROJECT INFORMATION** |
| Name – Facility      | Municipal Zoning Designation      |
| Address – Facility       | City      | State   | Zip Code      | County      |
| Name – Facility Contact Person      | Phone No.      | Email Address *(Print clearly or type.)*      |
| Facility Type  |
| [ ]  Hospital [ ]  Hospice [ ]  LTC Facility (Nursing Home) [ ]  CBRF [ ]  Community Substance Use Residential Service  |
| [ ]  Free-Standing Emergency Department [ ]  ESRD Attached [ ]  ESRD Attached [ ]  RCAC Attached  |
| [ ]  Medical Office Building Attached [ ]  Other Attached *(Specify.)*  |       |
|  |
| Project Description |
|       |
| DHS Facility License No.: |       | Related DHS Project No.: |   |   |   |   |   | **–** |   |   |   |   |   |
| **2. PLAN SUBMITTAL REQUEST** |
| **A. Type of Project(s)** *(Check all that apply.)*  |
| [ ]  New Building [ ]  Alteration (Level: [ ]  1 [ ]  2 [ ]  3) [ ]  New Addition [ ]  New License [ ]  Use Change [ ]  License Change |
| [ ]  Other Project *(Specify.):* |        |
|  |  |
| Proposed CBRF License[ ]  AA [ ]  AS [ ]  ANA [ ]  CA [ ]  CS [ ]  CNA | No. of Beds     | This building project will change the license from |     | to |     |
| Proposed Community Substance Use Residential Certification[ ]  Ambulatory [ ]  Semi-Ambulatory [ ]  Non-Ambulatory | CBRF License[ ]  Yes [ ]  No | No. of Beds     | Certification change from |     | to |     |
| B. Type of Plan Review(s) Requested *(Check all that are included in this application.)*  |
| [ ]  Building | [ ]  Building Systems – Emergency Lighting | [ ]  Component – Structural Precast |
| [ ]  HVAC | [ ]  Building Systems – Kitchen Hood | [ ]  Component–Footing and Foundation [ ]  Miscellaneous – Onsite Review [ ]  Plan Approval Extension |
| [ ]  Fire Protection Systems – Fire Alarm System | [ ]  Building Systems – Nurse Call |
| [ ]  Fire Protection Systems – Fire Sprinkler System | [ ]  Building Systems – Special Locking |
| [ ]  Building Systems – Essential Electrical | [ ]  Component – Structural Truss | [ ]  Revisions to Previously Approved Plan |
| [ ]  Miscellaneous – Other Plan Review *(Specify)*: |       |
|  |  |
| **3. PLAN REVIEW CONTACT PERSON** |
| **The contact person indicated below will receive your DHS-assigned reference number and instructions about online verification via email. The reference number will enable the applicant to verify the status of the plan application. A legible email address is necessary.** |
| Name – Plan Review Contact Person      | Phone No.      | Email Address      |
| **4. FEE CALCULATION TABLES**  |
|  |
| **TABLE A \*** |  | **TABLE B** |
| **Table 302.31-1****Fee Based on Total Gross Floor Area** |  | **DHS 124 / DHS 131****Fee Based on Project Dollar Value** |
| **Area**(Square Feet) | **Plan Fee**  |  | **Estimated Cost of Work Submitted** | **Fee** |
| Building | HVAC | Fire Alarm System | Fire Suppression System |  | Less than $4,999 | $125 |
| $5,000 – $12,499 | $175 |
| Less than 2,500 | $300 | $180 | $50 | $50 |  | $12,500 – $24,999 | $375 |
| 2,501 – 5,000 | $350 | $250 | $100 | $100 |  | $25,000 – $49,999 | $475 |
| 5,001 – 10,000 | $600 | $350 | $150 | $150 |  | $50,000 – $99,999 | $625 |
| 10,001 – 20,000 | $800 | $450 | $200 | $200 |  | $100,000 – $249,999 | $775 |
| 20,001 – 30,000 | $1,200 | $600 | $250 | $250 |  | $250,000 – $499,999 | $925 |
| 30,001 – 40,000 | $1,600 | $900 | $400 | $400 |  | $500,000 – $749,999 | $1,175 |
| 40,001 – 50,000 | $2,100 | $1,200 | $550 | $550 |  | $750,000 – $999,999 | $1,550 |
| 50,001 – 75,000 | $2,900 | $1,600 | $800 | $800 |  | $1,000,000 – $2,499,999 | $2,350 |
| 75,001 – 100,000 | $3,600 | $2,200 | $1,100 | $1,100 |  | $2,500,000 – $4,999,999 | $4,675 |
| 100,001 – 200,000 | $6,000 | $2,900 | $1,400 | $1,400 |  | $5,000,000 – $9,999,999 | $6,250 |
| 200,001 – 300,000 | $10,500 | $6,700 | $3,300 | $3,300 |  | $10,000,000 – $19,999,999 | $12,500 |
| 300,001 – 400,000 | $15,500 | $9,800 | $4,800 | $4,800 |  | $20,000,000 and Over | $20,000 |
| 400,001 – 500,000 | $18,500 | $12,000 | $6,300 | $6,300 |  |  |  |
| Over 500,000 | $20,000 | $13,500 | $7,100 | $7,100 |  |  |  |
|  |
| **TABLE C \*** |  | **TABLE D** |
| **Fee Based on Total Gross Floor Area** |  | **Fee Based on Project Dollar Value** |
| **Area**(Square Feet) | **Plan Fee**  |  | **Estimated Cost of Work Submitted** | **Fee** |
| Building and HVAC | Building Only | HVAC Only |  | Less than $4,999 | $100 |
| $5,000 – $24,999 | $300 |
| Less than 2,500 | $320 | $270 | $190 |  | $25,000 – $99,999 | $500 |
| 2,501 – 5,000 | $430 | $320 | $240 |  | $100,000 – $499,999 | $750 |
| 5,001 – 10,000 | $580 | $480 | $270 |  | $500,000 – $999,999 | $1,500 |
| 10,001 – 20,000 | $900 | $630 | $370 |  | $1,000,000 – $4,999,999 | $2,500 |
| 20,001 – 30,000 | $1,280 | $900 | $480 |  | $5,000,000 and Over | $5,000 |
| 30,001 – 40,000 | $1,690 | $1,220 | $690 |  | **TABLE E** |
| 40,001 – 50,000 | $2,280 | $1,590 | $900 |  | **Fee Based on Project Dollar Value** |
| 50,001 – 75,000 | $3,080 | $2,120 | $1,220 |  | **Estimated Cost of Work Submitted** | **Fee** |
| 75,001 – 100,000 | $3,880 | $2,600 | $1,690 |  | Less than $2,000 | $100 |
| 100,001 – 200,000 | $5,940 | $4,240 | $2,120 |  | $2,000 – $24,999 | $300 |
| 200,001 – 300,000 | $12,200 | $7,430 | $4,770 |  | $25,000 – $99,999 | $500 |
| 300,001 – 400,000 | $17,190 | $11,140 | $6,900 |  | $100,000 – $499,999 | $750 |
| 400,001 – 500,000 | $21.220 | $13,790 | $9,020 |  | $500,000 – $999,999 | $1,500 |
| Over 500,000 | $22,810 | $14,850 | $10,080 |  | $1,000,000 – $4,999,999 | $2,500 |
|  |  |  |  |  | $5,000,000 and Over | $5,000 |

**\* Area.** The area of a floor is the area bounded by the exterior surface of the building walls or the outside face of columns where there is no wall. Area includes all floor levels, such as subbasements, basements, ground floors, mezzanines, balconies, lofts, all stories, and all roofed areas including porches and garages, except for cantilevered canopies on the building wall. Use the roof area for free-standing canopies. Total area is the summation of all floor areas.

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| **5. FEE CALCULATION –  *Indicate the type of facility, if applicable, and the type of plan review(s) requested. Use information below and the tables in Section 4 to calculate your fees.*** |
| ***PLAN REVIEW REQUESTS – BUILDING, HVAC, FIRE ALARM SYSTEM, FIRE SUPPRESSION SYSTEM***  |

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| Facility Type: [ ]  **Hospital,** [ ]  **Hospice, or** [ ]  **Free-Standing Emergency Department (ED)**Plan Review(s): [ ]  Building [ ]  HVAC [ ]  Fire Alarm System [ ]  Fire Suppression SystemFee Table(s): Use Tables A and B | **Area Fee** *(Table A)* | $ |       |
|  Area (Sq. Ft.): |       |  |
| **Project Value Fee** *(Table*  *B)* | $ |       |
| Est. Cost: |       |  |
| Facility Type: **Building Attached to** [ ]  **Hospital,** [ ]  **Hospice, or** [ ]  **Free-Standing ED**Plan Review(s): [ ]  Building [ ]  HVAC [ ]  Fire Alarm System [ ]  Fire Suppression SystemFee Table(s): Use Table A; if no occupancy separation, use Tables A and B | **Area Fee** *(Table A)* | $ |       |
|  Area (Sq. Ft.): |       |  |
| **Project Value Fee** *(Table*  *B)* | $ |       |
| Est. Cost: |       |  |
| Facility Type: **LTC (Nursing Home)**Plan Review(s): [ ]  Building and HVAC [ ]  Building Only [ ]  HVAC OnlyFee Table(s): Use Tables C and D | **Area Fee** *(Table C)*  | $ |       |
|  Area (Sq. Ft.): |       |  |
| **Project Value Fee** *(Table*  *D)* | $ |       |
| Est. Cost: |       |  |
| Facility Type: **Building Attached to a LTC (Nursing Home)**Plan Review(s): [ ]  Building and HVAC [ ]  Building Only [ ]  HVAC OnlyFee Table(s): Use Table C; if no occupancy separation, use Tables C and D | **Area Fee** *(Table C)*  | $ |       |
|  Area (Sq. Ft.): |       |  |
| **Project Value Fee** *(Table*  *D)* | $ |       |
| Est. Cost: |       |  |
| Facility Type:[ ]  **CBRF** and[ ]  **Building Attached to a CBRF** Plan Review(s): [ ]  Building and HVAC [ ]  Building Only [ ]  HVAC OnlyFee Table(s): Use Table E | **Project Value Fee** *(Table*  *E)* | $ |       |
|  Est. Cost: |       |  |
| Facility Type: **Community Substance Use Residential Service**Plan Review(s): [ ]  Building [ ]  HVAC [ ]  Fire Alarm System [ ]  Fire Suppression System Fee Table(s): Use Table A | **Project Value Fee** *(Table*  *A)* | $ |       |
|  Est. Cost: |       |  |

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| ***PLAN REVIEW REQUESTS – BUILDING SYSTEMS AND FIRE PROTECTION SYSTEMS, IF SUBMITTED SEPARATELY***  |
| **Fire Protection Systems** Facility/Fee Table(s): **[ ]  Hospital, [ ]  Hospice, or [ ]  Free-Standing ED** *(Tables A and B)* [ ]  **LTC (Nursing Home)** *(Table D)* [ ] **CBRF** *(Table E)* [ ] **Community Substance Use Residential Service** *(Table A)*Plan Review(s): [ ]  Fire Alarm [ ]  Fire Sprinkler | **Area Fee** *(Table A)*  | $ |       |
| Area (Sq. Ft.): |       |  |
| **Project Value Fee** *(B or* *D or E)* | $ |       |
| Est. Cost: |       |  |
| **Building Systems**  |  |  |  | **Project Value Fee** *(B or* *D or E)* | $ |       |
| Facility / Fee Table: | [ ]  **Hospital** *(Table B)* | [ ]  **LTC (NH)** *(Table D)* | [ ]  **CBRF** *(Table E)* | Est. Cost: |       |  |  |
| Plan Review(s): | [ ]  Essential Electrical  | [ ]  Emergency Lighting  | [ ]  Kitchen Hood |
| [ ]  Nurse Call  | [ ]  Special Locking System  | [ ]  Miscellaneous Other:       |
| **Building Systems**  | [ ]  **Community Substance Use Residential Service** | If submitted as a stand-alone project or submitted following final inspection of the building, fee is $250. | $ |       |
| Plan Review(s): | [ ]  Essential Electrical  | [ ]  Emergency Lighting  | [ ]  Kitchen Hood |
|  | [ ]  Nurse Call  | [ ]  Special Locking System  | [ ]  Miscellaneous Other:       |
| **SUBTOTAL** | $ |       |
| **SUBTOTAL X .99** *(LTC – Nursing Home Only)* | $ |       |
| ***PLAN REVIEW REQUESTS – ADDITIONAL***  |
| **Plan Entry Fee:** [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED, [ ]  Community Substance Use Residential Service – **$100 per submittal**  [ ]  LTC (Nursing Home) – **$50 per submittal** | $ |       |
| ***ADDITIONAL PLAN REVIEW REQUESTS – AS NEEDED***  | $ |       |
| **Building Component Plans:** Plans for any other building component: [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED, [ ]  LTC (Nursing Home), [ ]  Community Substance Use Residential Service - **$250**  | $ |       |
| **Footings and Foundations:** Submitted prior to the submission of the building plans.  [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED, [ ]  LTC (Nursing Home), [ ]  Community Substance Use Residential Service - **$250**  | $ |       |
| **Permission to Start:** [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED, [ ]  Community Substance Use Residential Service – **$75**  [ ]  All Others – **$80** | $ |       |
| **Plan Approval Extension:** [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED – **$120**  [ ]  LTC (Nursing Home) – **$75** | $ |       |
| **Revisions to Previously Approved Plans:** [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED, [ ]  Community Substance Use Residential Service – **$75**  [ ]  All Others – **$100** | $ |       |
| **Structural Plans:** Plans submitted as independent projects, such as docks or antennae.  [ ]  Hospital, [ ]  Hospice, [ ]  Free-Standing ED or LTC (Nursing Home) - **$250**  | $ |  |
| **TOTAL FEES SUBMITTED** | $ |  |

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| **6. DESIGNER INFORMATION AND ATTESTATION**  |
| **DESIGNER STATEMENT** [Wis. Admin. Code §§ SPS 361.20, 361.31(1) and 361.40]**:** The designer indicated on this form is responsible for preparing or supervising the preparation of the plans, attests to the best of his/her knowledge that this submittal is accurate, and complies with the applicable codes of the Department of Safety and Professional Services and the Department of Health Services. If a building contains more than 50,000 cubic feet in volume, plans are required to be prepared, signed, sealed, and dated by a Wisconsin-registered architect, engineer, or designer [§ SPS 361.31(1)]. Signature and seals affixed to the plans shall be original or digital. |
| **DESIGNER 1** | **Type of Designer**[ ]  Building [ ]  Fire Protection [ ]  HVAC [ ]  Essential Electrical [ ]  Structural [ ]  Other: |       |
| Name – Design Firm      | Registration No.      |
| Name – Contact Person      | Phone No.      | Email Address **(MANDATORY)** *(Print clearly or type.)*      |
| Mailing Address – Street or P.O. Box      | City      | State   | Zip Code      |
| **SIGNATURE** – **Designer 1** | Date Signed *(mm/dd/yyyy)*      | Name *(Print clearly or type.)*      |
| **DESIGNER 2** | **Type of Designer** [ ]  Building [ ]  Fire Protection [ ]  HVAC [ ]  Essential Electrical [ ]  Structural [ ]  Other: |       |
| Name – Design Firm      | Registration No.      |
| Name – Contact Person      | Phone No.      | Email Address **(MANDATORY)** *(Print clearly or type.)*      |
| Mailing Address – Street or P.O. Box      | City      | State   | Zip Code      |
| **SIGNATURE** – **Designer 2** | Date Signed *(mm/dd/yyyy)*      | Name *(Print clearly or type.)*      |
| **7. SUPERVISING PROFESSIONAL INFORMATION AND ATTESTATION**  |
| **SUPERVISING PROFESSIONAL STATEMENT:** If a building contains more than 50,000 cubic feet in volume, I have been retained by the owner as the supervising professional, per Wis. Admin. Code § SPS 361.40, for the supervision of on-site observations to determine if the construction is in substantial compliance with the approved plans and specifications. Upon completion of construction, I shall file a written statement with the department and municipality certifying that, to the best of my knowledge and belief, construction has or has not been performed in substantial compliance with the approved plans and specifications. In the event that I am no longer associated with this project I shall file a compliance statement notifying the department, as such, and indicating the current status of compliance**.**  |
| **SUPERVISING PRO 1** | **Type of Supervising Professional**[ ]  Building [ ]  Fire Protection [ ]  HVAC [ ]  Essential Electrical [ ]  Structural [ ]  Other: |       |
| Name – Firm or Company      | Registration No.      |
| Phone No.      | Email Address **(MANDATORY)** *(Print clearly or type.)*      |
| **SIGNATURE** – **Supervising Professional 1** | Date Signed *(mm/dd/yyyy)*      | Name – Building *(Print clearly or type.)*      |
| **SUPERVISING PRO 2** | **Type of Supervising Professional** [ ]  Building [ ]  Fire Protection [ ]  HVAC [ ]  Essential Electrical [ ]  Structural [ ]  Other: |       |
| Name – Firm or Company      | Registration No.      |
| Phone No.      | Email Address **(MANDATORY)** *(Print clearly or type.)*      |
| **SIGNATURE** – **Supervising Professional 2** | Date Signed *(mm/dd/yyyy)*      | Name – Building *(Print clearly or type.)*      |
| **8. COMPONENT DESIGNER INFORMATION AND ATTESTATION** |
| **COMPONENT DESIGNER.** The Department of Health Services requires that the project designer review individual component submittals for compliance with the general design concept. The project designer and Department of Health Services shall rely on the seal of the component designers for compliance with the codes as they apply to their designs. |
| **COMPONENT DESIGNER 1** | **Type of Component Designer**[ ]  Structural [ ]  Footing and Foundation [ ]  Other: |       |
| **SIGNATURE** – **Component Designer 1** | Date Signed *(mm/dd/yyyy)*      | Name – Component Designer 1 *(Print clearly or type.)*      |
| **COMPONENT DESIGNER 2** | **Type of Component Designer**[ ]  Building [ ]  Fire Protection [ ]  HVAC [ ]  Structural [ ]  Other: |       |
| **SIGNATURE** – **Component Designer 2** | Date Signed *(mm/dd/yyyy)*      | Name – Component Designer 2 *(Print clearly or type.)*      |
| **9. OWNER/ENTITY INFORMATION AND ATTESTATION** |
| **OWNER STATEMENT:** I request that plans be reviewed for compliance with the applicable requirements set forth in Wis. Admin. Code chs. SPS 360-366 of the Department of Safety and Professional Services and in chs. DHS 83-134 of the Department of Health Services. I recognize that I am responsible for compliance with all code requirements in accordance with applicable conditions of approval. If a building is 50,000 cubic feet in total volume or greater, I will retain a supervising professional as required by § SPS 361.40 throughout construction to project completion. A Compliance Statement shall be submitted to the Department of Health Services by the supervising professional prior to occupancy. Plans shall be prepared, signed, sealed, and dated by a Wisconsin registered architect or professional engineer (ch. SPS 361) and signatures and seals affixed to the plans shall be original or digital.  |
| Name – Owner/Entity      |
| Mailing Address – Owner/Entity (Street or P.O. Box)      | City      | State   | Zip Code      |
| Name and Title – Contact Person      | Phone No.      | Email Address      |
| **SIGNATURE** **– Owner** (or Authorized Representative) | Date Signed *(mm/dd/yyyy)*      |
| *If signature is provided by an authorized representative, provide name and title below.* |
| Name – Authorized Representative      | Title – Authorized Representative      |