Local Zoning Form

__________________________ Date ________________________________

(This form is to be completed by the local zoning office and not by the facility applicant.)

TO: The Agency for Health Care Administration
    Hospital and Outpatient Services Unit
    2727 Mahan Drive, MS# 31
    Tallahassee, FL 32308

Regarding: Facility Name __________________________________________________
            Street Address ________________________________________________
            City, State, & Zip ____________________________________________
            Applicant's Name (owner) ______________________________________

The local zoning ordinances for the above street address have been reviewed. It has been
determined that the street address listed above does □ does not □ permit the operation of a
Level I or Level II Residential Treatment Facility (RTF).

Signature of Zoning Official ________________________________________________

Printed Name of Official _________________________________________________

Title ____________________________________________________________________

Zoning Agency Name _____________________________________________________

Street Address __________________________________________________________

City, State, Zip Code _____________________________________________________

If available, please staple a business card to this form as verification the form was completed by
the zoning authority.