



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.