



Okanogan County Public Health

1234 South 2nd Avenue
P.O. Box 231
Okanogan, WA 98840
(509) 422-7140
TDD (800) 833-6388

<http://www.okanogancounty.org/ochd/index.htm>

7/12/2005

APPLICATION FOR OVERNIGHT TRANSIENT ACCOMMODATIONS PERMIT TO OPERATE

THE OWNER OF AN OVERNIGHT TRANSIENT ACCOMMODATION MUST ASSURE THAT THE ESTABLISHMENT COMPLIES WITH LOCAL ZONING, BUILDING, ELECTRICAL, HEALTH, AND FIRE REGULATIONS AND IS RESPONSIBLE TO THE INDIVIDUAL AGENCIES CONCERNED.

FEE: _____

RECEIPT: _____

Please be certain this application is completed
and returned with your check made payable to:

**OKANOGAN COUNTY PUBLIC HEALTH
POST OFFICE BOX 231
OKANOGAN, WASHINGTON 98840**

NAME OF ESTABLISHMENT: _____

OVERNIGHT TRANSIENT ACCOMMODATIONS

BED & BREAKFAST

OWNER'S FULL NAME

MANAGER'S FULL NAME

MAILING ADDRESS

CITY

STATE

ZIP CODE

STREET ADDRESS (ESTABLISHMENT)

CITY

STATE

ZIP CODE

()

AREA CODE ~ TELEPHONE NUMBER

OF BEDROOMS

WATER SYSTEM INFORMATION

WATER SYSTEM CLASS: GROUP A GROUP B

SYSTEM ID #: _____

DATE LAST TESTED: _____

TEST RESULTS: SATISFACTORY UNSATISFACTORY

SEWAGE SYSTEM INFORMATION

SEWAGE DISPOSAL SYSTEM: PRIVATE PUBLIC

DATE SYSTEM LAST PUMPED: _____

IS THERE A HOT TUB OR SWIMMING POOL FOR GUEST USE? YES [] NO []

IF THIS IS A B&B WHAT MEALS WILL BE SERVED: [] BREAKFAST [] LUNCH [] DINNER

IF MEALS ARE TO BE SERVED, PLEASE ATTACH A MENU TO THIS APPLICATION.

IF THIS IS NOT A BED & BREAKFAST, ARE KITCHEN FACILITIES AVAILABLE IN THE LODGING UNITS? YES [] NO []

EXACT DIRECTIONS TO FACILITY: _____

MONTHS OF OPERATION: _____

OWNER/MANAGER INFORMED OF THE RESPONSIBILITY TO ASSURE APPROVAL BY THE OKANOGAN COUNTY PLANNING DEPARTMENT PRIOR TO OPERATION AS AN OTA YES [] OWNER/MANAGERS INITIALS _____

OWNER/MANAGER INFORMED OF OKANOGAN COUNTY RESOLUTION 57-2005 (OTA MORATORIUM) YES [] OWNER/MANAGERS INITIALS _____

HAS A WASHINGTON STATE BUSINESS LICENSE BEEN APPLIED FOR? YES [] NO []

SIGNATURE OF APPLICANT

DATE

PLEASE DO NOT WRITE BELOW THIS LINE.

APPROVED []

PERMIT NUMBER: _____

DENIED []

DATE ISSUED: _____

REASON FOR DENIAL: _____

COMMENTS: _____

HEALTH OFFICIAL

DATE