



Macon County
Public Health

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: _____
