



STATE OF FLORIDA
DEPARTMENT OF HEALTH
ONSITE SEWAGE TREATMENT AND DISPOSAL
SYSTEM
APPLICATION FOR CONSTRUCTION PERMIT

PERMIT NO. 22-0602
DATE PAID: 7/7/22
FEE PAID: 200.00
RECEIPT #: 1844529

APPLICATION FOR:

☐ New System ☒ Existing System ☐ Holding Tank ☐ Innovative
☐ Repair ☐ Abandonment ☐ Temporary ☐

APPLICANT: TEVIN JONES

AGENT: WOODYS ENTERPRISES TELEPHONE: 407-892-1900

MAILING ADDRESS: 1108 QUOTATION CT ST CLAIR, FL 34772
email: info@woodysenterprises.com

TO BE COMPLETED BY APPLICANT OR APPLICANT'S AUTHORIZED AGENT. SYSTEMS MUST BE CONSTRUCTED BY A PERSON LICENSED PURSUANT TO 489.105(3)(m) OR 489.552, FLORIDA STATUTES. IT IS THE APPLICANT'S RESPONSIBILITY TO PROVIDE DOCUMENTATION OF THE DATE THE LOT WAS CREATED OR PLATTED (MM/DD/YY) IF REQUESTING CONSIDERATION OF STATUTORY GRANDFATHER PROVISIONS.

PROPERTY INFORMATION

LOT: 46 BLOCK: _____ SUBDIVISION: Daks of Lake City P1 PLATTED: _____

PROPERTY ID #: 18-55-17-09280-146 ZONING: _____ I/M OR EQUIVALENT: ☒ Y ☐ N

PROPERTY SIZE: 4.5 ACRES WATER SUPPLY: ☐ PRIVATE PUBLIC ☐ ≤ 2000 GPD ☐ > 2000 GPD

IS SEWER AVAILABLE AS PER 381.0065, FS? ☒ Y ☐ N DISTANCE TO SEWER: _____ FT

PROPERTY ADDRESS: 3398 SW CUSTOM MADE CIR LAKE CITY 32024

DIRECTIONS TO PROPERTY: _____

BUILDING INFORMATION

☒ RESIDENTIAL ☐ COMMERCIAL

Unit No	Type of Establishment	No. of Bedrooms	Building Area Sqft	Commercial/Institutional System Design Table 1, Chapter 64E-6, FAC
1	<u>SHED</u>	<u>0</u>	<u>200</u>	<u>NO PLUMBING, NO ELECTRIC</u>
2				<u>(21-0148)</u>
3				
4				

☐ Floor/Equipment Drains ☐ Other (Specify) _____

SIGNATURE: [Signature] DATE: 6/24/22

DEPARTMENT OF HEALTH
BUREAU OF TUBERCULOSIS AND RESPIRATORY
DISEASES
DIVISION OF CONSUMPTION AND TUBERCULOSIS



REPORT OF THE
TUBERCULOSIS SURVEILLANCE
AND CONTROL
UNIT

NAME OF PATIENT
DATE OF BIRTH

DATE OF EXAMINATION
PLACE OF EXAMINATION

TO BE FILLED IN BY THE
EXAMINER
IS A TUBERCULOUS PATIENT?
IF YES, IN WHAT ORGAN?
IF YES, HOW LONG HAS HE BEEN
ILL?
IF YES, WHAT IS THE
PRESENT CONDITION?
IF YES, WHAT IS THE
TREATMENT?
IF YES, WHAT IS THE
PROGNOSIS?

NAME OF PHYSICIAN
ADDRESS

DATE OF REPORT
PLACE OF REPORT

NAME OF REPORTER
ADDRESS

DATE OF REPORT
PLACE OF REPORT

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NAME OF REPORTER
ADDRESS

DATE OF REPORT
PLACE OF REPORT

NAME OF REPORTER
ADDRESS

2000-0000

2000-0000



APPROVED

2000-0000