



SUBMISSION FOR PROJECT REVIEW
NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF LIFE SAFETY AND CONSTRUCTION
SFN 61466 (05-18)

INSTRUCTIONS: Type or print clearly. Send completed form, drawings, and supplemental information to:

FACILITY AND PROJECT INFORMATION

Name of Facility			
Mailing Address	City	State	Zip Code
Project Name			
Project Address	City	State	ZIP Code
Select all that apply: <input type="checkbox"/> Hospital <input type="checkbox"/> Critical Access Hospital <input type="checkbox"/> Skilled Care Facility <input type="checkbox"/> Basic Care Facility	Select all that apply: <input type="checkbox"/> New Construction <input type="checkbox"/> Rehabilitation Classification (see LSC Ch. 43) _____ <input type="checkbox"/> Bed capacity: Existing _____ Proposed _____ <input type="checkbox"/> Project is the result of a Life Safety Code survey deficiency		
Opinion of Probable Cost	Construction Type (see NFPA 220)		

CONTACT INFORMATION

Owner			
Address	City	State	ZIP Code
Telephone Number	E-Mail Address		

Designer			
Company			
Address	City	State	ZIP Code
Telephone Number	E-Mail Address		

Contractor (if known)			
Company			
Address	City	State	ZIP Code
Telephone Number	E-Mail Address		