

Electrical Permit Application



Permit Number: _____

Assoc. Permits: _____

Please read and follow all instructions on your application, submittal checklists and/or applicable supplemental forms carefully. Staff will not process incomplete applications. Please print or type legibly.

Site Address/Subdivision & Lot No.:			Suite Number(s):
Property Owner/Occupant:			Phone:
Address:			Cell:
City:	State:	Zip:	Fax:
E-Mail:			
Contractor Name:			Phone:
Address:			Cell:
City:	State:	Zip:	Fax:
State Contractor's License No.:		City Business License No.:	
Contact Person, if different:			Phone:
E-Mail:			Cell:
FAIR MARKET VALUE FOR FIXTURES, MATERIALS, AND LABOR: \$			
Specific Type of Electrical Work (Plan review required for all unless otherwise noted):			
<input type="checkbox"/> Single-Family or Duplex (no plan review required), Service Size: _____ amps <input type="checkbox"/> Multi-Family <input type="checkbox"/> Commercial <input type="checkbox"/> Generator <input type="checkbox"/> Medical, Institutional or School Facility			
Please complete as applicable (check, circle, and/or fill in):			
<input type="checkbox"/> New Building: _____ amps <input type="checkbox"/> Addition: _____ amps <input type="checkbox"/> Tenant Improvement <input type="checkbox"/> Temporary Power: _____ amps <input type="checkbox"/> Service Change: _____ amps <input type="checkbox"/> No. New Circuits: ____ <input type="checkbox"/> Limited Low Voltage <input type="checkbox"/> Portable Classroom/Mobile Home <input type="checkbox"/> Sign <input type="checkbox"/> Pool/Hot Tub, Sauna or Spa <input type="checkbox"/> Carnival (No. Concessions): _____ <input type="checkbox"/> Fire Alarm			
Description of Work:			
NOTICE			
<p>This permit becomes null and void if the authorized work has not been inspected by this department within 180 calendar days of issuance or for a period of 180 calendar days from the last inspection. The total life of this permit is limited to a maximum of 540 calendar days, provided it has not expired under the restrictions above. One extension request for 180 calendar days may be granted if a written request is submitted to the building official showing just cause before the expiration date.</p> <p>I hereby certify that I have read and examined this application and know the same to be true and correct. All provisions of laws and ordinances governing this type of work will be complied with whether specified herein or not. The granting of a permit does not presume to give authority to violate or cancel the provisions of any other state or local law regulating construction or the performance of construction.</p>			
Print Name of Owner/Agent: _____			
Signature of Owner/Agent: _____ Date: _____			

Over the Counter (OTC) Qualification Checklist

1. Is the occupancy defined as any of the following facilities?	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
<table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;">Hospital</td> <td style="width: 50%; border: none;">Ambulatory Surgery Facility</td> </tr> <tr> <td style="border: none;">Nursing Home Unit or Long-Term Care Unit</td> <td style="border: none;">Renal Hemodialysis Clinic</td> </tr> <tr> <td style="border: none;">Boarding Home</td> <td style="border: none;">Residential Treatment Facility for Psychiatrically Impaired Children and Youth</td> </tr> <tr> <td style="border: none;">Assisted Living Facility</td> <td style="border: none;">Adult Residential Rehabilitation Center</td> </tr> <tr> <td style="border: none;">Private Alcoholism Hospital / Alcoholism Treatment Facility</td> <td style="border: none;">Educational Facility</td> </tr> <tr> <td style="border: none;">Private Psychiatric Hospital</td> <td style="border: none;">Institutional Facility</td> </tr> <tr> <td style="border: none;">Maternity Home</td> <td style="border: none;"></td> </tr> </table>	Hospital	Ambulatory Surgery Facility	Nursing Home Unit or Long-Term Care Unit	Renal Hemodialysis Clinic	Boarding Home	Residential Treatment Facility for Psychiatrically Impaired Children and Youth	Assisted Living Facility	Adult Residential Rehabilitation Center	Private Alcoholism Hospital / Alcoholism Treatment Facility	Educational Facility	Private Psychiatric Hospital	Institutional Facility	Maternity Home		
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<p><i>If answered "Yes", then will this scope of work include:</i> <i>*At least one "Yes" required for OTC.</i></p>															
a) A lighting specific project that results in an electrical load reduction on each feeder involved in the project.	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
b) A low voltage system.	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
c) A modification to an existing installation where <u>ALL CONDITIONS ARE TRUE</u> :	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
<ul style="list-style-type: none"> - Service or distribution equipment involved is rated less than 100 amperes and does not exceed 250v - Does not involve emergency systems other than listed unit equipment per NEC 700.12(F). - Does not involve branch circuits or feeders of an essential electrical system as defined in NEC 517.2. 															
<p><i>If answered "No" on #1, please answer the following questions.</i> <i>*All answers must be "No" in order to qualify for OTC.</i></p>															
2. Is this work an installation or alteration to a service feeder rated 100 amperes or greater?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
3. Is more than 100 amperes being added to the service or feeder?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
4. Is this a commercial generator installation or alteration?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
5. Is all work on the electrical system operating at or over 600 volts?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
6. Is 60% or more of luminaires changing and is there an increase in the lighting load?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
7. Is this work in an area that has been determined to be a hazardous (classified) location by the NEC?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
8. Is this an installation of a switch or circuit breaker rated 400 amperes or more?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
9. Is this a solar photovoltaic system?*	Yes <input type="checkbox"/> / No <input type="checkbox"/>														
<p>NOTICE</p> <p>Inaccurate information indicated on this checklist may result in the need for plan review. If upon inspection, it is discovered that your scope of work does not match the work indicated on this worksheet, you may be issued a Stop Work Order and will cease work until plans have been submitted, reviewed approved, and issued.</p>															