

CURRENT USE	TYPE OF USE(S)	Name of User	Total Floor Space of Use (sf)	# of Employees		# of Off Street Parking Spaces	Hours of Operation	# of ADA Parking Spaces	Bathroom Facilities	Shifts (Y/N)	Exterior Lighting	User Remaining (Y/N)		
				Full Time	Part Time									
														1
														2
														3
														4
														5
														6
														7
													8	

PROPOSED USE	TYPE OF USE(S)	Name of User	Total Floor Space of Use (sf)	# of Employees		# of Off Street Parking Spaces	Hours of Operation	# of ADA Parking Spaces	Bathroom Facilities	Shifts (Y/N)	Exterior Lighting	User Same as Above (Y/N)		
				Full Time	Part Time									
														1
														2
														3
														4
														5
														6
														7
													8	

OFFICE USE ONLY

UCC PERMITS		PUBLIC HEARINGS		OTHER AGENCY REVIEW		Additional Review/Permits	
<input type="checkbox"/> Plumbing	<input type="checkbox"/> Electrical	<input type="checkbox"/> Conditional Use	<input type="checkbox"/> Liquor License Transfer	<input type="checkbox"/> Borough Planning	<input type="checkbox"/> County Planning	<input type="checkbox"/> Stormwater	<input type="checkbox"/> Sanitary Sewer
<input type="checkbox"/> Mechanical	<input type="checkbox"/> Building	<input type="checkbox"/> Zoning Hearing Board	<input type="checkbox"/> Borough Council	<input type="checkbox"/> Conservation District	<input type="checkbox"/> State Dept of Health	<input type="checkbox"/> Driveway	<input type="checkbox"/> Highway Occupancy
<input type="checkbox"/> Fire Code	<input type="checkbox"/> Accessibility	<input type="checkbox"/> Other _____		<input type="checkbox"/> Other _____	<input type="checkbox"/> PA One Call	<input type="checkbox"/> Other _____	<input type="checkbox"/> Non-conforming Use

Yes No Approved Accessibility Plan on File Plan approval date: _____

_____ Zoning District PA One Call Serial Number _____

Zoning Permit Approved Date: _____ By: _____

Zoning Permit Denied Date: _____ By: _____

Reason(s):
