

DEPARTMENT OF RESOURCE MANAGEMENT

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SOLANO COUNTY

Site# 24H- _____

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HOUSING PERMIT APPLICATION

Housing Facility Name: _____

Applicant Name: _____

Site Address: _____

Email Address: _____ Telephone: _____

- Housing Permit Type:
- Hotel/Motel (Any food service in excess of 25 squarefeet of shelf stable product requires a food permit)
 - Bed and Breakfast (Only Breakfast and a light afternoon snack are permissible and require a food permit)
 - Agricultural Homestay (Ag. is the primary source of income and meals served requires a food permit)

Manager Name: _____

Mailing Address: _____

Number of Rooms*: _____ Is there a restroom available outside of the rooms for staff use: Yes No

***A B&B shall not have more than 20 guestrooms, an Ag. Homestay shall not have more than 6 guestrooms. This includes the California Health and Safety Code definitions only. Consult your local planning jurisdiction for local code restrictions which may be more stringent.**

Do you provide food onsite for your guests: Yes (Site # _____) No

*** Any food service in excess of 25 squarefeet of shelf stable product requires a food permit**

Do you have a pool/spa onsite for use by your guests*? Yes (Site # _____) No

***A sign and pool enclosure is required for unpermitted pools and spas.**

Potable Water Purveyor: _____

***Potable water is required for all Housing Facilities, either a Local or State regulated water system is required.**

Attach the following:

- Site Schematic
- Copy of Business License
- Applicable Fee (based on number of rooms)
- Website: _____

I certify that, I understand that obtaining a housing permit is required for all transient occupancy within Solano County and agree to provide access for inspection a minimum of twice per year in addition to complaint investigations to the regulatory authority. The provided information is true and that I will comply with all applicable local, city, county, and state requirements.

Owner: _____

Print Name Signature Date

Registration/Review Fee \$ _____ Paid yes no Receipt# _____

E.H. Specialist: _____ Date Received: _____ Date Approved: _____