PRIVATE PROVIDER PLAN COMPLIANCE AFFIDAVIT
Florida Statutes §553.791(6)

Project Name:

Project Address:

Application / Permit #: Folio #:

☐ Construction Documents ☐ Revisions
☐ Shop Drawings ☐ As-Builts
☐ Other:

Private Provider Firm:

Private Provider Address:

Telephone: Fax:

Email:

I HEREBY CERTIFY that to the best of my knowledge and belief, the documents submitted for the above referenced project were reviewed according to, and are in compliance with, the Florida Building Code and all local amendments thereto, either by myself or by the affiant identified below, who is duly authorized to perform plans review pursuant to Section 553.791, Florida Statutes, and holds the appropriate license or certificate:

Name of person reviewing the plans (if applicable):

Florida License/Registration/Certification numbers:

Discipline and Plan Sheets covered by this affidavit:

Signature of Reviewer: Date:

X ___________________________ Signature of Qualifier

STATE OF __________________
COUNTY OF ________________
Sworn to (or affirmed) and subscribed before me this _____ day of __________, 20_______ by:

__________________________
(Type / Print Qualifier Name)

(NOTARY’S SIGNATURE as to Qualifier)

Notary Name
(Print, Type or Stamp Notary’s Name)

Personally Known ______ or Produced Identification ______

Type of Identification Produced ___________________________________________
X______________________________________________
Signature of Qualifier

STATE OF __________________________
COUNTY OF _________________________
Sworn to (or affirmed) and subscribed before me this _____ day of
______________________, 20_____ by:

________________________________________
(Type / Print Qualifier Name)

(NOTARY’S SIGNATURE as to Qualifier)

Notary Name __________________________________
(Print, Type or Stamp Notary’s Name)

Personally Known ___ or Produced Identification ___

Type of Identification Produced ____________________________

Private Provider: ______________________________________

Florida License No.: _________________________________

Provider Seal/Signature/Date