Call Sanitarian Between
8 a.m. and 9 a.m.
664-5281 / 873-7291

№ 0511

# PROPERTY DESCRIPTION

APPLICATION FOR- (Not a Permit) ( ) Improvements Permit ( ) Zoning Permit ( ) Special Use ( ) Subdivision Approval ( ) Other

Proposed Use: Dwelling

Location: Wallace Rd

TAX MAP NO. _____

| Tax Map No. | Township | Jurisdiction | Zoning |
|---|---|---|---|
| 2K-10-A-43 | Barium Springs | Iredell | R-20 |

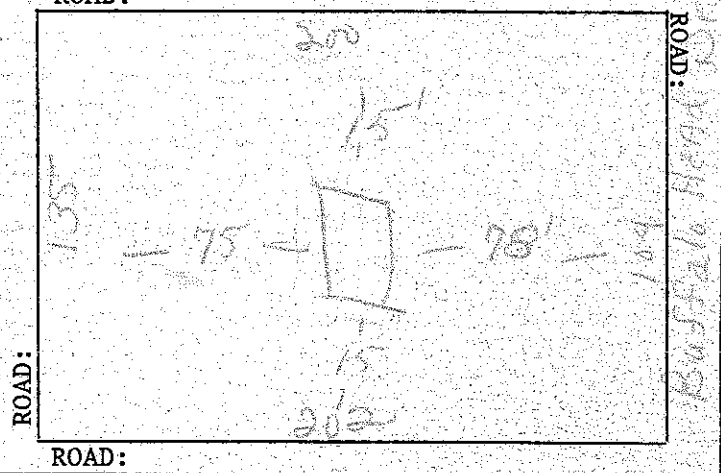
| Subdivision/Mobile Home Park | Lot No. | Lot Size | Flood Plain ( ) yes ( ) no |
|---|---|---|---|
| Wallace Est | 13 | | |

| Approx. Area to be disturbed | Engineering Firm | Contact | Phone | Street Address |
|---|---|---|---|---|
| | | | | |

REQUIRED INFORMATION FOR IMPROVEMENTS PERMIT - IREDELL COUNTY HEALTH DEPARTMENT

SKETCH MAP

On the lot to be built on or to be used, show the property lines and the actual dimensions of the lot, the size and shape of any and all buildings located or to be located on the lot showing the distances from lot lines. Show setback of main building on adjacent lot and their use.




| OWNER | ADDRESS | PHONE NO. |
|---|---|---|
| H.F. Rucker | PO Box 855 Mooresville | 872-7[illegible] |

I certify that all of the statements made in this application and any attached documents are true, complete and correct to the best of my knowledge and belief and are made in good faith. I understand that false information may be grounds for rejection of this application. Authorized Health Department and Inspection Department Representatives are granted right of entry to make evaluations or inspections and to release information upon public request.

X _____ 2-23-87

Signature of Owner or Authorized Agent — Application Date

If permitted, the following minimum zoning requirements must be met, unless the Health Department requires more land area or other qualifications are indicated in the remarks.

Lot area 20,000 sq. ft. Front yard depth 35 ft. Corner yard depth 25 ft.

Lot width 100 ft. Side yard depth 15 ft. Rear yard depth 35 ft.

LAND USE INDICATED (is) (is not) PERMITTED IN THE ZONING DISTRICT.

REMARKS: _____

ZONING ADMINISTRATION DIVISION

Approved by _____ Date 2-23-87

WHITE: Original CANARY: Inspection Copy PINK: Health Dept. GOLD: Owner