PROPERTY DESCRIPTION

APPLICATION FOR-(X) Improvements Permit ( ) Zoning Permit ( ) Special Use ( ) Subdivision Approval (X) Other
(NOT A PERMIT)
Proposed Use: Commercial Storage Addition

Tax Map No.	Parcel No.	Township	Jurisdiction	Zoning
10G-B-9		Bethany		RA

Subdivision	Lot No.	Section No.	Lot Size	Road No.	Flood Plain
			.70A	21 N.	( )yes (X)no

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

REQUIRED INFORMATION FOR IMPROVEMENTS PERMIT - IREDELL COUNTY HEALTH DEPARTMENT

Type of Facility (check on and complete) -

( ) Single family dwelling	No. of bedrooms ( )	No. of other rooms w/closets ( )	
( ) Mobile home	No. of Bedrooms ( )	No. of other rooms w/closets ( )	
( ) Multi-family dwelling	No. of units ( )	No. of bedrooms per unit ( )	No of other rooms with closets ( )
(X) Business	Total employees per day (28)	Type of business	Waste-( ) Domestic water ( ) Industrial

( ) Other (Specify)

( ) New structure ( ) Existing structure ( ) Renovate (X) Addition

Garbage Disposal Unit to be Installed ( ) yes (X) no

Water Supply Source (X) Private ( ) Public ( ) Private off-site

Attach site plan showing property lines, location of proposed structures (including driveways, patios, decks, etc.) and any existing structure, if requested by Health Dept.

OWNER P. A. Laws	Mailing Address Rt 4 Box 217 Statesville N.C.	Telephone No. 876-3463
APPLICANT C. A. Laws	Mailing Address	Telephone No.

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 Representatives are granted right of entry to make evaluations or inspections and to release information upon public request

X C. A. Laws _____
Signature of Owner or Authorized Agent Date

Land use indicated (is) (is not) permitted in the zoning district. 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 _____ sq.ft. Front yard depth _____ ft. Corner yard depth _____ ft.
Lot width _____ ft. Side yard depth _____ ft. Rear yard depth _____ ft.
Aggragate both sides _____

Remarks: _____

Zoning Administration Division

County — E. T. Hunt — June 1/1983
Jurisdiction Processed by Date

WHITE: Original CANARY: Inspection Copy PINK: Health Department GOLD: Owner

Tax Map No. 10G-B-9 Parcel No. _____ Permit No. _____ Date June 1/83 By E. T. Hunt