

CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR PUBLIC HEALTH
APPLICATION FOR PERMIT OR LICENSE



Application for permit/license to operate a: _____

Facility Profile: Permit/License Fee _____ Inspection Fee _____ Total _____

Date Paid: _____ Check Cash Money Order

Establishment No.: _____ Program: _____ County: _____

Action: New Change Deleted Reactivate

Status: Active Inactive Hold No. App Suspended

Sanitarian Number: _____ Inspection Interval: _____ Type of Est.: _____

Type of Service: Sit Down/Full Cafeteria/Continental Carry-Out/Retail Market

Caterer (Comm.) Interstate Conveyance No Service Type

Water Supply: Public Private Other Sewage: Public Private Other

Federal ID: _____ Census Tract: _____

TO BE COMPLETED BY APPLICANT – PLEASE PRINT LEGIBLY

Name of Establishment: _____

Sort Name (Leave Blank): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Owner's Name: _____ Last 4 SSN _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ E-mail: _____

Billing Address (if different from above): _____

City: _____ State: _____ Zip Code: _____ Phone # _____

Military status: Active Duty Reserves National Guard Honorably Discharged Veteran

I hereby certify that the above statements are true and correct to the best of my knowledge. I understand that a false statement may disqualify me for permits or licenses.

Applicants Signature: _____ Date: _____

Establishment GPS Coordinates

Latitude _____
 DEG MIN SEC

Longitude _____
 DEG MIN SEC

Quantity 1	Unit Measure	
	Machines	A
	Mobile Home Spaces	M
	Rooms	R
	Seats	S
	Trucks	T
	Gallons	G
	Boarders/Beds	B

Quantity 2	Unit Measure	
	Commissaries	C
	RV Spaces	V
	Feet	F
	Male Student	M
	Female Students	E
	Residents	R
	Square feet	Q

Catering Operation Drive Through Window Variance Planned Construction No. _____

Language: _____ Menu Type: _____ Risk Type: _____

State Owned Fee Paying WIC Print Permit Roster Truck Only

Home County _____ Group ID _____

Pool Information Type: Indoor Outdoor Continuous TOR _____

Disinfectant type: _____ Pump: _____ Filter: _____

Bond Information

Insurance Company Individual Bond Needed Not Required Cancelled

SEPTIC TANK TRUCKS

Number	Make	Model	Year	Capacity

Construction Plan Approval New or Additional Plumbing Construction Approval

By: _____

Health Authority: _____ Date: _____