



FOOD PROGRAM APPLICATION

Office use only: BLA _____

SERVICE REQUESTED

- New Business
 Change of Ownership
 Change of Business Name previous business name _____
 Plan Review (fill out entire application)
 other: please specify _____ Opening date* _____

ATTN: FINAL APPROVAL TO OPEN AND OPERATE MUST BE GRANTED BY THIS DEPARTMENT IN WRITING PRIOR TO OPENING DATE

TYPE OF ESTABLISHMENT:

- Restaurant seating capacity _____
 Mobile Food
 Kitchen Rental
 Bed/Breakfast
 Retail Food/Market square footage of retail area _____
 School
 other: please specify _____

OWNER #1 INFORMATION:

OWNER #2 INFORMATION (if applicable):

Name: _____	Name: _____
Home Address: _____	Home Address: _____
City/St/Zip: _____	City/St/Zip: _____
Phone #: _____ Alt. # _____	Phone #: _____ Alt. # _____
Email Address: _____	Email Address: _____

FACILITY INFORMATION:

SEND ANNUAL HEALTH PERMIT BILL TO:

Facility Name: _____	<input type="checkbox"/> Owner 1 address	<input type="checkbox"/> Owner 2 address
Facility Address: _____	<input type="checkbox"/> Facility Address	<input type="checkbox"/> *other-please specify below
City/St/Zip: _____	* _____	
Phone #: _____ Business Email address: _____		

FOR PLAN REVIEW ONLY - REQUESTOR INFORMATION:

Plan review requirements: 3 sets of plans, 1 set of equipment specifications and plan review fee

- NEW BUSINESS/MAJOR REMODEL (FO930/FO935)
 REMODEL (FO920/FO910) (additional fees may apply)
 EXPEDITE (additional fees apply)
- Company Name: _____ Contact Person: _____
 Company Address: _____ Email Address: _____
 City/St/Zip _____ Phone #: _____ Alt. # _____

By signing below, the owner or authorized representative agrees to operate in accordance with all applicable state and local regulations, laws, and procedures needed to ensure compliance. Notify Environmental Health in writing if business closes or change of ownership occurs. HEALTH PERMITS ARE NON-TRANSFERABLE. For plan review applications, the owner information will be used for the health permit issuance unless our office is notified with updated information.

ATTN: SUBMITTAL OF THIS APPLICATION DOES NOT CONSTITUTE PERMIT APPROVAL.

If you would like additional information about the Safe Surplus Food Donation Program, please visit smchealth.org/fooddonation

Print Owner/Representative 1: _____ Signature _____ Date _____
 Print Owner/Representative 2: _____ Signature _____ Date _____