

FOOD SERVICE LICENSE APPLICATION

- New Establishment
- Transfer of Ownership (See FSE Ownership Transfer Screening Form)
- Itinerant Food Vendor (See Itinerant Food Vendor Information Form)

ESTABLISHMENT Name _____

Address _____

Town _____ State _____ Zip Code _____

Establishment Phone _____ *Establishment Fax _____

*Email Address _____ @ _____

*Please provide an email address and/or fax number that can be used to communicate with the establishment. Emergency Notifications will be sent via email or fax only.

Establishment Mailing Address (if different than above) _____

Town _____ State _____ Zip Code _____

OWNER of Establishment _____

Owner Home Phone (for EHHD use only) _____ Fax _____

Owner Email Address (for EHHD use only) _____ @ _____

Mailing Address (if different than establishment) _____

Town _____ State _____ Zip Code _____

The LICENSEE is the person designated by the owner of the establishment to receive all notices required to be sent to the establishment. If the establishment owner is a business name, the owner **must designate a person as the licensee** and provide contact information in the space below. (Contact information will be used by EHHD only)

Licensee _____

Phone _____ Fax _____

Licensee Email Address (for EHHD use only) _____ @ _____

Mailing address (if different than establishment mailing address) _____

Town _____ State _____ Zip _____

MANAGER of Establishment _____

Contact Information (for EHHD use only in the event of an emergency)

Home Phone _____ Fax _____

This application must be submitted to Eastern Highlands Health District with the license fee applicable to the assigned Food Service Establishment Class. See fee schedule for appropriate fee.

PLEASE FILL OUT ALL SECTIONS BELOW

Type of Establishment <input type="checkbox"/> Mobile/Itinerant Vendor <input type="checkbox"/> Restaurant <input type="checkbox"/> Deli/Convenience Store <input type="checkbox"/> Grocery Store <input type="checkbox"/> Caterer <input type="checkbox"/> Bakery <input type="checkbox"/> Healthcare Institution <input type="checkbox"/> Church/Organization <input type="checkbox"/> School/Daycare <input type="checkbox"/> Other _____	Seating Capacity _____ Service Method (Check All That Apply) <input type="checkbox"/> Buffet/Salad Bar <input type="checkbox"/> Take Out <input type="checkbox"/> Catering <input type="checkbox"/> Sit Down (Indoor/Outdoor)	Hours of Operation (when are you open?) Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat _____ Sun _____ If Seasonal Use: Indicate Months of Operation _____ to _____
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Sewage Disposal <input type="checkbox"/> Public Sewer <input type="checkbox"/> Septic System	Grease Trap <input type="checkbox"/> Indoor <input type="checkbox"/> Outdoor <input type="checkbox"/> AGRU <input type="checkbox"/> None	Water Supply <input type="checkbox"/> Community <input type="checkbox"/> NTNC <input type="checkbox"/> TNC <input type="checkbox"/> NOT REGISTERED WITH DPH*(see below) <input type="checkbox"/> Itinerant Source _____	Water Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
<p>*An unregistered water supply serving a food service establishment must be screened by the CT DPH for classification as a public or private water source. (Contact the DPH-Drinking Water Section). If the water supply is classified as a private supply you are required to submit a Water Quality Report with this application. All water samples must be taken by a qualified individual and tested by a certified laboratory.</p>			

FOR CLASS 3 & 4 FOOD SERVICE ESTABLISHMENTS, COMPLETE THE FOLLOWING:

Name of Qualified Food Operator (QFO) _____

Approved Test Course _____

The QFO shall be onsite, in a supervisory position with authority, responsible for training all personnel ensuring safe food handling practices and compliance with CT Public Health Code Section 19-13-B42.

Name(s) of Alternate QFO(s) _____

Approved Test Course _____

The designated alternate shall act in the position of QFO, when the above listed QFO cannot be present.

YOU MUST SUBMIT A COPY OF THE QFO COURSE CERTIFICATE BEFORE LICENSE WILL BE ISSUED

THE UNDERSIGNED AGREES TO COMPLY WITH THE EHHD SANITARY CODE AND THE CT PUBLIC HEALTH CODE. FOR DUE CAUSE, THIS LICENSE MAY BE SUSPENDED BY THE DIRECTOR OF HEALTH.

Authorized Signature _____ **Date** _____

FOR EHHD OFFICE USE ONLY			
License Fee Paid _____	Date Received _____	Check _____	Receipt _____
FSE# _____	Class _____	License Approved (signature) _____	Date _____
Notes : _____			
Revised March 2012			