GREENE COUNTY HEALTH DEPARTMENT

Food Retail Establishment Application

Permit Year: _____

Permit Fee: $50.00

Late Fee: $100.00

Please complete and return this application with the appropriate attachment(s) and permit fee to:
Greene County Health Department • 217 East Spring Street, Suite 1 • Bloomfield, IN 47424

A late fee is added to temporary and seasonal applications received less than 10 business days prior to event or start of season. A late fee is added to annual applications (01/01-12/31) received after December 15th.

Missing information or incomplete application will not be processed, and a Food Permit will not be issued.

_____***Temporary Food Establishment*** *– means a food establishment that operates at a fixed location for a period of time not more than 14 consecutive days in conjunction with a single event orcelebration.*

_____***Seasonal Establishment*** *– means a retail establishment that operates during specific months of the year, usually weather related, as designated by the operator.*

_____***Annual Establishment*** *– means a retail establishment that operates on a routine schedule year-round.*

Business Owner Information

Owner's Name:_____

Address, City, State & Zip:_____

Phone #:_____Mobile #:_____

E-mail Address: _____

Type of Business/Ownership: ***(✓one)*** ☐ Individual ☐ Partnership ☐ Corporation ☐ Members

☐ Nonprofit 501(c)(3) Tax ID Number: _____

Current tax-exempt certificate MUST be submitted with a nonprofit application.
Nonprofits who sale food less than 15 days per calendar year do not require a permit.

Application status: ***(✓one)*** ☐ New ☐ Renewal ☐ Owner/Operator Change

Plan Review documents MUST be submitted with owner/operator change or a new application.

Food Establishment *(the name commonly used or d/b/a & physical location)*

Establishment Name:_____Phone #:_____

Address, City, State & Zip:_____

City, State and Zip Code:_____

Type of Food Establishment: ☐ Convenience Store ☐ Grocery Store ☐ Concession/Food Stand (Walk-up only)

☐ Restaurant/Bar ☐ Commercial Kitchen/Commissary ☐ Custom Processor ☐ Nutrition Site/Pantry ☐ Private Club

☐ Residential Cafeteria ☐ School Lunchroom ☐ Banquette/Conference ☐ Catering ☐ Bed & Breakfast or Hotel Kitchen

Water Source: ***(✓one)*** ___Municipal___Private/Well **Wastewater Disposal:** ***(✓one)***____Municipal____Private/Septic

Establishment Schedule: Sun:_____-_____Mon:_____-_____Tue:_____-_____Wed:_____-_____

Thu:_____-_____ Fri:_____-_____ Sat:_____-_____(times/hours of operations)

☐ Seasonal operations from_____*(mm/dd/yy)* to_____*(mm/dd/yy)*

☐ Temporary operations from_____*(mm/dd/yy)* to_____*(mm/dd/yy)*

CONTINUE ON BACK

Establishment Name:_____

On-Site Manager's Name:_____Manager's Mobile #:_____

Manager's E-Mail Address:_____

Certified Food Protection Manager Name:_____Expiration Date:_____

Accredited food protection manager certification MUST accompany application unless your food establishment is exempt; see Title 410 IAC 7-22-15 (g). An acceptable certification has an Accredited Program by the American National Standards Institute and the Conference for Food Protection (ANSI-CFP).

Menu Items *(list food items or attach menu to application)*: _____

_____

_____

_____

_____

If selling raw, frozen processed meat products, please indicate the follow:

1) ☐ UDSA Approved Process Plant ☐ BOAH Approved Process Plant ☐ Certificate Customer Processor

   Name of Plant/Processor: _____

   Address, City, State, Zip: _____

2) Method for keep product frozen during retail: _____

   _____

Event Information *(if applicable)*

Name of Event:_____

Location of Event:_____

Dates and Hours of Operation:_____

Event Coordinator Name:_____Mobile #:_____

Event Coordinator's E-mail Address: _____

Applicant's Signature:_____Amount Enclosed: $_____

Notes:

- ***Permit Fee is Non-Refundable and Permit is Non-Transferable.***
- ***Annual food permits expire on December 31st.***
- ***Types of Payment Accepted:***
  - ***Cash***
  - ***Money Order***
  - ***Check (Business checks only; no personal checks.)***
  - ***Debit/Credit Cards***

Greene County Health Department 217 E. Spring Street, Suite 1, Bloomfield, Bloomfield, IN 47424
Phone (812) 384-4496; Fax (812) 384-2037; health@co.greene.in.us; www.co.greene.in.us\health

For Office Use

Paid by: ***(✓ one)*** ☐ Cash ☐ Business Check ☐ Money Order ☐ Credit Card

Date Fee Paid:_____Processed by:_____

Amount Paid: $_____Receipt Book #:_____

Permit #:_____