

Amount Due: \$ \_\_\_\_\_  
Date Paid: \_\_\_\_\_  
Paid By: \_\_\_\_\_

CALVERT COUNTY HEALTH DEPARTMENT  
Division of Environmental Health  
P.O. Box 980  
Prince Frederick, MD 20678  
410-535-3922/301-855-1557  
Fax # 410-535-5252  
[www.calverthealth.org](http://www.calverthealth.org)

License# \_\_\_\_\_

APPLICATION FOR LICENSE TO OPERATE A FOOD SERVICE FACILITY

Application is hereby made to operate a food establishment in accordance with the Health-General Article §21-305, Annotated Code of Maryland and COMAR 10.15.03. Please make checks payable to: "Calvert County Health Department".  
***Licenses to operate a food service facility expires on October 31<sup>st</sup>.***

LICENSE FEE: \_\_\_ HIGH                      \_\_\_ MODERATE                      \_\_\_ LOW                      \_\_\_ SEASONAL  
(4 consecutive months)

(Fees are listed on page 2 of the Environmental Health Fee Schedule under the heading Food Service Facility)

Type of Application: \_\_\_ RENEWAL                      \_\_\_ CHANGE OF OWNERSHIP                      \_\_\_ NEW

PLEASE PRINT OR TYPE

**FACILITY INFORMATION**

Name of Facility: \_\_\_\_\_  
Facility Email Address: \_\_\_\_\_  
Former Name of Facility (if applicable): \_\_\_\_\_ Date of Ownership Change: \_\_\_\_\_  
Facility Phone Number: \_\_\_\_\_ Facility Contact: \_\_\_\_\_  
Physical Address: \_\_\_\_\_  
Facility Mailing Address: \_\_\_\_\_  
Owner's Name: \_\_\_\_\_ Owner's Phone Number: \_\_\_\_\_  
Owner's Mailing Address: \_\_\_\_\_

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**Corporate Information (if applicable)**

Name: \_\_\_\_\_ Tax ID# (FEIN): \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Corporate Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_ Email Address: \_\_\_\_\_

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**Property Owner**

Name: \_\_\_\_\_ Email Address: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_



**Statement of Workmen's Compensation Insurance**

Maryland Health-General Code Annotated Section 1-202 requires that before any license or permit can be issued under the Health-General Article to an employer to engage in an activity in which the employer may employ any individual, the employer must file with the issuing authority a certificate of compliance with the State Workmen's compensation laws indicating the employer's workmen's compensation insurance policy or binder number.

Please check  the option box below that applies to you, provide the requested information, sign and date the form, and return it with the attached application.

1. I have workmen's compensation insurance.

Insurance Company \_\_\_\_\_

Policy or Binder Number \_\_\_\_\_

2. A waiver has been received from the Workmen's Compensation Commission. (ATTACH A COPY OF THE WAIVER).

3. As provided by Maryland Annotated Code Article 101, I am exempt from having workmen's compensation insurance. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE).

4. I am self-insured. Approval of self-insurance has been received from the Workmen's Compensation Commission. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE).

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Title

\_\_\_\_\_  
Company Address

\_\_\_\_\_  
Type of License

\*\*\*\*\*

FOR OFFICE USE ONLY

New Permit/License \_\_\_\_\_ Approved \_\_\_\_\_ Denied \_\_\_\_\_ Hold \_\_\_\_\_

Reason \_\_\_\_\_

By \_\_\_\_\_ Date \_\_\_\_\_

**STATEMENT OF WORKMENS' COMPENSATION INSURANCE –  
ADDITIONAL INFORMATION**

If a proprietor does not have employees he/she may qualify for a waiver or exemption of self-insurance is not required. In order to comply with Maryland Health-General Code Annotated Section 1-202, a copy of the certificate of compliance (with official seal) for a waiver or exemption from the workmen's' compensation Board must be submitted to the Calvert County Health Department, Division of Environmental Health, P.O. Box 980, Prince Frederick, MD 20678.

In order to receive a waiver or exemption of this insurance, a notarized letter must be submitted to the board stating your situation. All letters should be addressed to:

State of Maryland  
Workers' Compensation Commission  
10 East Baltimore Street  
Baltimore, MD 21202-1641

The Workers' Compensation Commission may be contacted at:

(410) 864-5100  
(800) 492-0479 (Outside Metro Baltimore)  
711 or (800) 735-2258 (Maryland Relay-Hearing Impaired)  
Email: [info@wcc.state.md.us](mailto:info@wcc.state.md.us)  
Website: <http://www.wcc.state.md.us>

If you have self-insurance, approval must be received from the Workmen's Compensation Commission and a copy of the certificate of compliance shall be submitted to this department.

If you wish to inquire on receiving self-insurance, you may contact:

INJURED WORKERS INSURANCE  
8722 Loch Raven Blvd  
Towson, MD 21286-2235  
1-800-264-IWIF (4943), Monday-Friday, 8:00am to 5:00pm

If you have any further questions or need additional information, please do not hesitate to call our department weekdays between the hours of 8:00 a.m. and 4:30 p.m. at the following phone number: (410) 535-3922.

**\*NOTE: Workmen's Compensation Insurance is not required for Excluded Organizations with volunteer workers.**

**CERTIFICATE OF COMPLIANCE**  
**Application Instructions**

**NOTE:**

**Md. Code Ann., Lab. & Empl. §9-201 requires an employer with one or more employees to carry workers' compensation insurance.**

The purpose of this Certificate of Compliance is to identify those employers that are not required to carry workers' compensation insurance coverage and to enable that employer to apply for, and obtain, a license or permit from a government agency that requires proof of workers' compensation insurance coverage. **A Certificate of Compliance is not workers' compensation insurance and is not binding on the Workers' Compensation Commission under any circumstances.**

Before a governmental unit may issue a license or permit to an employer to engage in an activity in which the employer might employ a covered employee, the employer shall submit to the governmental unit:

- (1) a certificate of compliance with this title; or
- (2) the number of a workers' compensation insurance policy or binder.

If an employer is not covered by a workers' compensation insurance policy, an application to secure a Certificate of Compliance must be submitted to the Worker's Compensation Commission pursuant to Labor & Employment Article §9-105.

**Eligibility:**

An employer may secure a Certificate of Compliance in the name of the employer, only if the employer is an entity set forth in Labor and Employment Article, §9-206(b)(1) – (b)(5) with no covered employees other than Corporate officers or limited liability company members who have elected to be exempt from workers' compensation coverage.

Sole Proprietors, Partners and Individuals who are owner/operators of a Class F Vehicle, and are not employers, are not eligible to receive a Certificate of Compliance. For the above business types, a letter of exemption will be supplied that can be submitted to the licensing agency.

Mail Application to: **Workers' Compensation Commission**  
**Attention: IC&R Division**  
**10 East Baltimore Street**  
**Baltimore, Maryland 21202-1641**

Facsimile Applications ARE NOT accepted. Do not photocopy or electronically reproduce. Required signatures must be original.

An applicant who receives notice of disapproval may: (1) reapply for a certificate of compliance or (2) appeal the rejection in accordance with § 10-222 and § 10-223 of the State Government Article.



WORKERS' COMPENSATION COMMISSION

APPLICATION FOR CERTIFICATE OF COMPLIANCE



INSTRUCTIONS: Please review the instructions on page 2 completely prior to completing this application. Complete in Adobe Reader, type or print legibly.

Name of Business: \_\_\_\_\_

Business Address (P.O. Box is not acceptable): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Federal Employer Identification Number or Social Security Number(s) \_\_\_\_\_

Name of Owner(s) or Member(s):

\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_, \_\_\_\_\_, of the above-named business hereby affirm, under the penalties of perjury, (Name of Authorized Representative) (Title/Company Position) that workers' compensation is not required pursuant to Labor and Employment Article: (Select the appropriate reason with a check in the adjacent box. Do not modify or qualify the stated reason.)

- a.  §9-206(b)(1) (Close Corporation) — Attach Exclusion Form IC-16
- b.  §9-206(b)(2) (General Corporation) — Attach Exclusion Form IC-16
- c.  §9-206(b)(3) (Farm Corporation) — Attach Exclusion Form IC-16
- d.  §9-206(b)(4) (Professional Corporation) — Attach Exclusion Form IC-16
- e.  §9-206(b)(5) (Limited Liability Company) — Attach Exclusion Form IC-16

Signature \_\_\_\_\_ Date \_\_\_\_\_

**COMMISSION ACTION**

The application for Certificate of Compliance is:  APPROVED  DISAPPROVED

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_  
Workers' Compensation Commission



WORKERS' COMPENSATION COMMISSION

EXCLUSION FORM

INSTRUCTIONS: Pursuant to Labor & Employment Article §9-206, Annotated Code of Maryland, officers or members of certain business entities may elect to be exempt from workers' compensation insurance coverage by filing this Exclusion Form with the Commission. To exercise this option, the officer or member making the election must sign this document. Mail the original form to the Workers' Compensation Commission, a copy to the insurer of the company/corporation, and keep a copy for your files.

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP \_\_\_\_\_

Type of Company:

- Close Corporation, General Corporation, Farm Corporation, Professional Corporation, Limited Liability Company

Insurance Company Name: \_\_\_\_\_

Date Insurance Company Notified: \_\_\_\_\_

Table with 3 columns: Typed Name and Title of the Officer or Member Electing Exclusion, % of Ownership, Personal Signature. Includes a total row with values (Total cannot exceed 100) and 0.00.

NOTE: By signing this Exclusion Form, each officer or member affirms under the penalties of perjury that the information contained in this form is true and correct as to that officer or member, to the best of the officer's or member's knowledge, information, and belief.