

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

License# _____

APPLICATION FOR LICENSE TO OPERATE A MOBILE UNIT 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 31st.

LICENSE FEE: ___ HIGH \$300.00 ___ MODERATE \$230.00 ___ LOW \$180.00 ___ SEASONAL \$180.00
(4 consecutive months)

PLEASE PRINT OR TYPE

Type of Application: ___ RENEWAL ___ CHANGE OF OWNERSHIP ___ NEW

FACILITY INFORMATION

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

MOBILE UNIT INFORMATION (Attach a photograph of the unit)

Make: _____ Model: _____ Year: _____ Tag#/State: _____
Color/Markings: _____ Vin#: _____
Name on title: _____ Email address: _____

COMMISSARY AGREEMENT INFORMATION (Please attach a signed copy of agreement)

Name of Facility Used: _____ Commissary Owner's Name: _____
Commissary Facility Address: _____
Phone Number: _____ Days & Hours Commissary is used: _____
Describe the use of Commissary (ie, food storage, preparation, ect): _____

FACILITY OPERATIONS

Operating: Year-Round Seasonal (4 consecutive months) Provide Start Date and End Date: _____

Provide Days and Hours Unit is Operating: _____

SET-UP LOCATIONS AND/OR LOCAL EVENTS

Location Sites: _____

Local Events Attended: _____

MENU AND FOOD PREPARATION (Include a copy of your approved HACCP)

WATER SUPPLY Public **SEWERAGE** Public **Grease Tank Size:** _____

Private Private **Service Agreement for Pumping:** _____

Food Prepared In Unit: _____

Food Prepared 12 Hours or More In Advance: _____

Food Supply: _____

WORKERS COMPENSATION INSURANCE INFORMATION

Does this business have covered employees (Worker’s Compensation Insurance)? Yes _____ No _____

If “Yes”, please provide Carrier Name: _____ Policy# _____

If “No”, please attach copy of exemption or self-insurance certificate

BY SIGNING THIS APPLICATION I AGREE I HAVE REVIEWED THE APPLICATION IN ITS ENTIRETY. ALL INFORMATION PROVIDED IS TRUE, ACCURATE, AND COMPLETE TO THE BEST OF MY KNOWLEDGE. **IF THE APPLICATION IS NOT COMPLETE IT WILL BE RETURNED.**

I UNDERSTAND THAT FALSIFICATION OF THIS APPLICATION MAY RESULT IN THE DENIAL, SUSPENSION OR REVOCATION OF THE PERMIT.

BY SIGNING THIS APPLICATION, I HEREBY ACKNOWLEDGE THAT MY BUSINESS IS IN COMPLIANCE WITH MARYLAND WORKER’S COMPENSATION LAWS AND REGULATIONS.

APPLICANT’S SIGNATURE APPLICANT’S PRINTED NAME DATE

OFFICIAL USE ONLY: DATE ISSUED: _____ APPROVED BY: _____

HACCP APPROVAL DATE: _____ PRIORITY: HIGH _____ MODERATE _____ LOW _____

COMMENTS: _____