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 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 $525.00 ____MODERATE $410.00 ____LOW $290.00 ____SEASONAL $290.00 (4 consecutive months)

PLEASE PRINT OR TYPE

Type of Application: ____RENEWAL ____CHANGE OF OWNERSHIP ____NEW

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: ____

****

Corporate Information (if applicable)

Name: ____ Tax ID# (FEIN): ______________________________

Mailing Address: ____

Corporate Contact Person: _____________________________ Phone Number: ______________________________

Fax Number: _______________________________________ Email Address: ______________________________

****

Property Owner

Name: ____ Email Address: ______________________________

Mailing Address: ____

Phone Number: ____

Facility Operations

Operating: Permane Seasonal (4 consecutive months) Provide Start Date and End Date:

Food Service Facility Type (Check all that apply)

Full Service Restaurant/Lounge School Confections (Candy, Ice Cream) Grocery-Market/Deli

Market/Prepackaged Carry-Out Only Bar/Lounge/Liquor Store Soft serve Ice Cream/Yogurt

Hospital Nursing Home Institution Other________________ Caterer

Number of Seats Provided: _________________

Days and Hours of Operation: «TimeofOperation»____

WATER SUPPLY Publi **SEWERAGE** Public **Grease Tank Size**: ______________________________

Private Private **Service Company for Pumping**: ___________________

Trash Service Company: ____

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: ____

Change of Ownership Fee Due: $_________________

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
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
Workers' Compensation Commission
Date

10 East Baltimore Street Baltimore, Maryland 21202-1641

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:________________

Typed Name and Title of the Officer or Member Electing Exclusion	% of Ownership	Personal Signature
______________________	________	______________
______________________	________	______________
______________________	________	______________
______________________	________	______________
______________________	________	______________
(Total cannot exceed 100)	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.