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 $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: _____

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 ☐Private **SEWERAGE** ☐Public ☐Private **Grease Tank Size**: _____ **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: _____