HEALTH PERMIT APPLICATION

Date:_____ Check one: New: _____Renewal: _____

Business Name: _____

Business Address: _____

City-State-Zip: _____

Mailing Address: _____

City-State-Zip:_____

Owner(s) Name(s):_____Phone:_____

Email: _____

If mobile unit-list license number: _____

Name and address of commissary: _____

_____

Hours/Days of operation: _____

Describe operation and types of food/menu offered: _____

_____

Signature of Applicant: _____

For Office Use Only

Application Received: _____

Payment Received: _____Amt. Paid: _____Permit #_____

Permit Issued-Date: _____Permit Expires: _____

City of New Fairview Authorized Representative: _____