# 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:** _____________________________________