

WABASH COUNTY HEALTH DEPARTMENT

89 WEST HILL STREET, WABASH, INDIANA 46992

Phone: (260) 563-0661 Ext. 1249; Fax: (260) 563-6082

APPLICATION FOR ANNUAL, SEASONAL, VALUE ADDED FOOD OR TEMPORARY FOOD SERVICE PERMIT

WABASH COUNTY ORDINANCE 2007-85-1 STIPULATES THAT IT SHALL BE UNLAWFUL FOR ANY PERSON TO OPERATE A FOOD SERVICE ESTABLISHMENT, MOBILE FOOD SERVICE, TEMPORARY FOOD SERVICE OR FOOD MARKET IN WABASH COUNTY WHO DOES NOT POSSESS A VALID PERMIT FROM THE HEALTH OFFICER OR ITS AUTHORIZED REPRESENTATIVE. (ISDH RULE 410 IAC 7-24)

ALL FORMS MUST BE COMPLETE AND ACCURATE, WITH SIGNATURE, AND RETURNED WITH THE APPROPRIATE FEE(S). IF THE APPLICATION IS NOT RECEIVED **SEVEN (7) DAYS PRIOR** TO THE EVENT, A LATE FEE OF **\$50.00** SHALL BE ASSESSED. *NOTE: SUBMITTING THIS APPLICATION DOES NOT GUARANTEE A PERMIT WILL BE ISSUED.*

YOUR PERMIT AND FEE ARE:

_____ ANNUAL: **\$100.00 PER YEAR**

- IF YOU KNOW OF ANY EVENTS YOU PLAN TO ATTEND THIS YEAR, PLEASE COMPLETE THE ATTACHED ANNUAL PERMIT - EVENT REMINDER FORM. ADDITIONAL REMINDER FORMS ARE AVAILABLE ON OUR WEBSITE AT FOODSERVICES.WABASHCOUNTY85.US OR YOU MAY EMAIL: rmofield@wabashcountv.in.gov.

_____ SEASONAL: **\$100.00 PER YEAR**

_____ VALUE ADDED FOODS: **\$25.00 PER YEAR**

_____ TEMPORARY: **\$15.00 PER DAY** (For the Designated Event): Number of Days: _____ Amount Due: _____

- Event Name: _____ Location: _____

- From: ____ / ____ / ____ To: ____ / ____ / ____ Date Set-up: ____ / ____ / ____ Time: _____

AS PART OF THE TEMPORARY PERMIT, THE FOLLOWING IS A BRIEF CHECKLIST OF SOME OF THE EQUIPMENT AND REQUIREMENTS NEEDED TO OPERATE A TEMPORARY FOOD UNIT IN WABASH COUNTY. PLEASE CHECK ALL THAT APPLY TO YOUR MOBILE, TENT, BOOTH OR INSIDE BUILDING.

EQUIPMENT CHECKLIST:

1. () A three bay sink with hot and cold running water shall be provided for each mobile, or three tub's for wash, rinse, and sanitize.
2. () A hand-washing sink with at least warm running water, soap and individual paper towels, or a thermos with a spigot that provides free running water with a 5 gallon discard bucket is required.
3. () A wastewater tank utilized to hold wastewater until it is properly disposed of.
4. () Any hose used to supply water to the unit must be of food grade quality and a backflow device provided if applicable.
5. () To check concentration of sanitizing solutions for wiping cloths and final rinse, a chemical test kit shall be provided.
6. () A stem-type thermometer shall be provided to check the temperature of hot and cold food items.
7. () A thermometer shall be provided in each cold storage unit.

PERSONNEL:

1. Wear clean clothing and effective hair restraint.
2. Persons who are currently ill from diarrhea, vomiting, fever, sore throat or who have infected lesions shall be prohibited from food handling operations.
3. Wash hands thoroughly each time you enter the concession, and thereafter as needed.
4. Absolutely **NO SMOKING** by any employee in the concession trailer.
5. **NO BARE HAND CONTACT ON READY TO EAT FOODS (410 IAC 7-24 SEC. 171).**

PLEASE NOTE THE FOLLOWING:

- **FAX NUMBER OR EMAIL IS REQUIRED**
- **ANY FEES AND/OR PERMITS ARE NOT REFUNDABLE NOR TRANSFERABLE**
- **PLEASE MAKE CHECK OR MONEY ORDER PAYABLE AND MAIL TO:** WABASH COUNTY HEALTH DEPARTMENT
ATTN: FOOD DIVISION
89 WEST HILL STREET
WABASH, INDIANA 46992

PLEASE COMPLETE APPLICATION ON FOLLOWING PAGE AND RETURN BOTH PAGES

Type or print clearly in ink and return application form to above address.

TODAY'S DATE: ___/___/___

NAME OF FOOD SERVICE: _____

PHONE: _____ FAX: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

WATER SUPPLY: _____ Public _____ Private SEWAGE: _____ Public _____ Private

TYPE OF BUSINESS: CORPORATION FRANCHISE INDIVIDUAL LLC OTHER: _____
(PLEASE CIRCLE ONE)

NAME OF OWNER: _____ PHONE: _____

CELL: _____ E-MAIL ADDRESS: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

NAME OF CERTIFIED EMPLOYEE: _____
(UNLESS EXEMPT BY MENU)

CERTIFICATION NUMBER: _____ EXPIRATION DATE: ___/___/___

IF ANY FOOD ITEMS ARE PREPARED (IN PART OR IN WHOLE) OTHER THAN ON SITE, LIST THE LICENSED FACILITY AND ADDRESS:

FACILITY NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

ANNUAL AND TEMPORARY ONLY: List ALL foods and beverages to be prepared, sold and/or served.

LIST DAILY OPENING AND CLOSING TIMES: Be specific! If times change, please notify the Health Department.

OPENING MONTH: _____ CLOSING MONTH: _____ YEAR: _____

	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
START TIME							
STOP TIME							

APPLICATION IS HEREBY MADE FOR AN ANNUAL, SEASONAL, VALUE ADDED FOOD OR TEMPORARY PERMIT TO OPERATE A FOOD ESTABLISHMENT IN WABASH COUNTY. IT IS AGREED THE FOOD ESTABLISHMENT WILL COMPLY WITH THE PROVISIONS OF THE INDIANA STATE DEPARTMENT OF HEALTH RULE 410 IAC 7-24, WABASH COUNTY FOOD ORDINANCE 2007-85-1 AND FEE SCHEDULE ORDINANCE NO. 04-2004.

SIGNATURE OF APPLICANT: _____ DATE: ___/___/___

PRINT NAME: _____ TITLE: _____

OFFICE USE ONLY: Date Issued: ___/___/___ Receipt Number: _____ Permit Number: _____