WABASH COUNTY HEALTH DEPARTMENT

89 WEST HILL STREET, WABASH, INDIANA 46992
Phone: (260) 563-0661 Ext. 1249; Fax: (260) 563-6082

APPLICATION FOR 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)**

Failure to return BOTH pages COMPLETE and ACCURATELY may cause delay and possible penalty fees.

Type or print clearly in ink and return application form (2 PAGES) to above address. PERMITTED YEAR: _____

NAME OF ESTABLISHMENT: _____

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: _____

MAIL APPLICATION TO: _____ *Business* _____ *Owner* ***ALL Permits Will Be Mailed to Establishments ONLY!***

NAME OF MANAGER: _____ HOME PHONE: _____
(OR PERSON IN CHARGE)

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

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

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

LIST THE ESTABLISHMENT'S DAILY OPENING AND CLOSING TIMES (Please Be Specific):

SUN _____ MON _____ TUE _____ WED _____ THUR _____ FRI _____ SAT _____

_____ _____ _____ _____ _____ _____ _____

Before daily opening, please indicate what time food preparation starts in your establishment.

_____ _____ _____ _____ _____ _____ _____

ATTENTION: MANAGER OR PERSON IN CHARGE

THE **MANAGER**, OR THE **PERSON IN CHARGE** OF THE FOOD ESTABLISHMENT, WILL BE RESPONSIBLE FOR COLLECTING THE PERMIT FEE, COMPLETING THE APPLICATION FOR FOOD SERVICE PERMIT AND SUBMITTING THEM TO THE WABASH COUNTY HEALTH DEPARTMENT BEFORE **DECEMBER 31, *CURRENT YEAR***. IF THE BUSINESS IS A CORPORATION, FRANCHISE, ETC., PLEASE CONTACT YOUR REPRESENTATIVE WITH THIS INFORMATION.

A PERMIT WILL NOT BE ISSUED UNTIL ALL NECESSARY FORMS ARE ***COMPLETED*** AND PERMIT FEES ARE SUBMITTED TO THE WABASH COUNTY HEALTH DEPARTMENT.

FEE FOR A FOOD SERVICE PERMIT: $125.00 PER YEAR ***(This Permit Expires on December 31 Following Year)***

PLEASE MAKE CHECK PAYABLE AND MAIL TO:

WABASH COUNTY HEALTH DEPARTMENT
ATTN: FOOD DIVISION
89 WEST HILL STREET
WABASH, INDIANA 46992

PENALTIES:

IF THE PERMIT FEE, AS PRESCRIBED, IS NOT RECEIVED BY THE WABASH COUNTY HEALTH DEPARTMENT POSTMARKED ON OR BEFORE DECEMBER 31ST, CURRENT YEAR, A PENALTY OF $100.00 PER DAY SHALL BE IMPOSED.

THE LATE FEE OF $100.00 PER DAY SHALL NOT EXCEED THIRTY (30) DAYS; AFTER WHICH TIME THE ESTABLISHMENT WILL BE CLOSED. THE ESTABLISHMENT WILL NOT BE RE-OPENED UNTIL THE PRESCRIBED FEE, PLUS THE LATE PENALTY FEE IS PAID IN FULL AND THE APPLICATION IS PROCESSED.

PLEASE NOTE THE FOLLOWING:

- ***A FAX NUMBER OF E-MAIL ADDRESS IS REQUIRED***
- *ANY FEES AND/OR PERMITS ARE NOT REFUNDABLE NOR TRANSFERABLE*
- *FAILURE TO RETURN ALL PAGES COMPLETE AND ACCURATELY MAY CAUSE DLEAY AND POSSIBLE PENTALY FEES.*
- ***CHANGE OF OWNERSHIP REQUIRES CONTACTING THE WABASH COUNTY HEALTH DEPARTMENT***

SIGNATURE OF APPLICANT: _____ **DATE:** _____/_____/_____

PRINT NAME: _____ **TITLE:** _____

FOR OFFICIAL USE ONLY, PLEASE DO NOT WRITE BELOW THIS LINE

DATE ISSUED: _____/_____/_____ PERMIT NUMBER: _____ AMOUNT RECEIVED: $_____

CHECK NUMBER: _____ LATE FEE: $_____ RECEIPT NUMBER: _____ APPROVED BY: _____

PERMIT MAILED: _____/_____/_____ BY: _____ RECEIPT MAILED: _____/_____/_____ BY: _____ APPLICATION: _____/_____/_____

NOTES: _____

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