

APPLICATION TO OPERATE A 6 MONTH FOOD SERVICE ESTABLISHMENT

Important please read! This application must be filled out completely, legibly and fees attached before your license will be processed. Incomplete applications will be returned to applicant.

For Office Use Only:
 Establishment # _____
 New-start date ____/____/____
 Renewal-date ____/____/____

Vendor/Business Information:

Name of Vendor/Business: _____

Address: _____

Phone Number: _____ E-mail: _____

Water Supply: (✓ one) Public _____ Private Well _____

Sewer: (✓ one) Public _____ Private Septic _____

Manager/Person in Charge Name: _____

Manager/Person in Charge Phone Number: _____

Emergency contact phone: _____

Start Date: ____/____/____ End Date: ____/____/____

Days & Hours of operation

***OT=Operating Times**

Mon. _____ OT Tues. _____ OT Wed. _____ OT Thurs. _____ OT

Fri. _____ OT Sat. _____ OT Sun. _____ OT ✓ all that apply

***Please attach a copy of the menu**

License Fees:

Licensing fees cannot be transferred between owners and establishment locations

_____ Class 1A High Risk 6 MONTH \$472.00
 _____ Class 2A Medium Risk 6 MONTH \$392.00
 _____ Class 3A Low Risk 6 MONTH \$250.00

_____ Class NFP 6 Month-Not-for-Profit \$0.00 Tax Exempt # _____
 _____ High _____ Med _____ Low

*To assure timely permit processing, please submit permit application and payment **two weeks** before start date.
 _____ initials of person filling out form
 Late Fees may apply if you operate in consecutive 6 month licensing per
 Late Fee (1-day past expiration)= \$100 late fee

Re-inspection Fees:

First Re-inspection Fee \$125.00
 Second Re-inspection Fee \$150.00
 Third Thru Fifth Re-inspection Fee \$200.00
 Sixth or more Re-inspection Fee \$300.00

IL Certified Food Service Manager Name	Identification Number

2-102.12 Certified Food Protection Manager

(A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.

(B) This section does not apply to certain types of FOOD ESTABLISHMENTS deemed by the REGULATORY AUTHORITY to pose minimal risk of causing, or contributing to, foodborne illness based on the nature of the operation and extent of

FOOD preparation. (Low Risk)

Owner Information:	
Owner Name:	_____
Owner Address:	_____
	City State
Phone Number:	_____

Mailing/Billing Information:	
<p>"Below is the address that all of the mailings/billings from Sangamon County Department of Public Health are to go to. If at anytime this address changes, it is my responsibility to notify Sangamon County Department of Public Health."</p>	
	_____ initials of person filling out form
Name of Person responsible for Receiving Billings & Mailings:	_____
Mailing/Billing Address:	_____
	City
Phone Number:	_____

<p>By signing this application you are stating that all of the information on the front and back of this form is true and correct, and that if there are any changes to this information you are responsible for notifying the Sangamon County Department of Public Health of the changes in a timely manner.</p>	
Signature of Applicant x _____	Date _____

For Official Use Only	
Approving Authority: _____	Approval Date: ____/____/____