



Public Health
Prevent. Promote. Protect.

Decatur County Health Department

315 S. Ireland St. Greensburg IN 47240

Food Service Permit Application

Please send this form along with your payment by January 1st, 2024. If you are requesting non-profit status, please submit a copy of your 501 c 3. Fill out this form as you want it to appear on your permit. **An incomplete form will not be processed for a permit.** Please enclose a copy of your entire menu. Late fees will be applied every 45 days after February 15th, 2024. (1-9 employees) \$100 (10-20 employees) \$250 (21+ employees) \$300.

OWNERSHIP INFORMATION

Facility:

Owner's Name:

Address:

City:

ST:

ZIP:

Owner's Cell Phone:

Ownership Legal Type: ☐ Association ☐ Corporation ☐ Individual ☐ Partnership ☐ Non-Profit (please include 501c3)
Other (please specify)

MANAGEMENT INFORMATION

Person in Charge has the oversight of a zone, district or region.

Name of person in Charge:

Title:

Telephone:

Operator has oversight of the preparation or serving of food at the establishment.

Name of Operator:

Title:

Telephone:

Enclose copies with application

Name(s) of Certified Food Handler(s):

Date of Exam:

MAILING ADDRESS

Address for correspondence, including application or email address if you prefer:

☐ Please send all future correspondence via email

Name:

Email Address:

Address:

City:

ST:

ZIP:

Office Use Only

Establishment
#

Menu Type

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Meals Served (check all that apply) and Hours of Operation (please note if closed all day)

☐ Breakfast

☐ Lunch

☐ Dinner

☐ Cater

☐ Mobile Unit

| | Sunday | Monday | Tuesday | Wednesday | Thursday | Friday | Saturday |
|-------|--------|--------|---------|-----------|----------|--------|----------|
| Open | | | | | | | |
| Close | | | | | | | |

Number of Employees (Food Service Facility) _____ Square Footage (Retail Food Store) _____

The Undersigned Hereby applies for a permit to operate a Food Service Establishment pursuant to Decatur County Ordinance 2006-4. The undersigned hereby attests to the accuracy of the information provided in this application and affirms that the undersigned will comply with the ordinance and allow the Decatur County Health Official full access to the establishment.

Signature of Applicant(s): _____

Printed Name of Applicant(s): _____



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***** Fee Schedule*****

Food Service Facility

Employees

| | |
|-------|----------|
| 1-9 | \$200.00 |
| 10-20 | \$300.00 |
| 21+ | \$600.00 |

Retail Food Store

Square

Footage

| | |
|---------------------------|----------|
| 1-1000 ft ² | \$200.00 |
| 1001-8000 ft ² | \$300.00 |
| >8000 ft ² | \$600.00 |

***** Please enclose copies of menus and food handler certifications. *****

**Please make check payable to:
Decatur County Health Department**