



Public Health
Prevent. Promote. Protect.

Decatur County Health Department

315 S. Ireland St. Greensburg, IN 47240

Mobile Food Establishment Permit Application

Please send this form along with your payment 15 days prior to the event or by January 1, 2026 if you are purchasing a yearly permit. 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, food protection manager certification, and commissary agreement.**

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:	<input type="checkbox"/> Please send all future correspondence via email
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Name:		
Email Address:		
Address:		
City:	ST:	ZIP:

Office Use Only

Establishment #	Menu Type 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/>
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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*****

Yearly	\$200.00
Per Event	\$50.00

*****PLEASE ENCLOSE A COPY OF YOUR MENU, FOOD PROTECTION MANAGER
CERTIFICATION, AND COMMISSARY AGREEMENT*****

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