



**Decatur County Health Department**

**315 S. Ireland St.**

**Greensburg IN, 47240**

**Phone: (812) 663-8301**

**Fax: (812) 663-4174**

**TEMPORARY FOOD SERVICE APPLICATION FORM**

**Fees are \$50.00 per permit. Please enclose copies of menus and food handler certifications.**

Facility Name (As it will appear on permit): \_\_\_\_\_

Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

E-mail: \_\_\_\_\_

Website: \_\_\_\_\_

Event for which you are applying: \_\_\_\_\_

**OWNERSHIP INFORMATION:**

Ownership Legal Type: ☐ Association ☐ Corporation ☐ Individual ☐ Partnership

☐ Non-Profit (Please include 501 C-3) ☐ Other: \_\_\_\_\_

---

Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Owner's Phone Number: (\_\_\_\_) \_\_\_\_\_

Owner's E-mail: \_\_\_\_\_

---

**MANAGEMENT INFORMATION:**

Name of person in Charge: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

Name of Operator: \_\_\_\_\_ Title: \_\_\_\_\_

Phone Number: (\_\_\_\_) \_\_\_\_\_

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

Date of Exam: \_\_\_\_\_

---

*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):**

\_\_\_\_\_