TEMPORARY FOOD SERVICE APPLICATION FORM

Decatur County Health Department
801 N. Lincoln Street
Greensburg IN 47240
(812)663-8301 Fax (812)663-4174

Please send this form along with your payment 15 days prior to the event. If you are requesting tax exempt 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***. Please note that our annual fees have changed due to severe budget cuts. Fees are now $50.00 per permit.***

Facility Name (As it will appear on permit)		Phone Fax
Facility Address:	City: _____ Zip Code: _____	E-mail: Website:
Event for which you are applying:		

OWNERSHIP INFORMATION

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

☐ Non-Profit (*please include 501c3)* ☐Other_____

Owner's Name: _ Address: City ST: ZIP :	Owner's Phone Owner's Cell Phone Owner's Email _____

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

CityST: ZIP

Office Use Only

Establishment #	Menu Type ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

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The following information is REQUIRED if applicable. Please return this completed form with page one.

Name of Establishment: *_____

Number of Seats_____ Total Square Footage_____

TOTAL Number of Employees_____ Managers_____ Food Handlers_____

Waiters_____ Deliverers_____

Estimated Number of Meals served weekly_____

Meals Served (check all that apply)

Breakfast ☐ Lunch ☐ Dinner ☐ Cater ☐ Mobile Unit ☐

Days and Hours of Operation

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Opening Time							
Closing Time							

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): _____

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

Permits are $200.00 for all Bed and Breakfast, Retail Food and Mobile Permits.

Please make check payable to:

Decatur County Health Department