Harrison County Health Department

Food Protection

241 Atwood Street, Suite 200 – Corydon, Indiana 47112

Phone (812) 738-3237, Extension 1013 – Fax (812) 738-4292

Website: www.HarrisonCountyHealth.Com

Office hours: Monday – Friday, 8:00 AM – 4:30 PM

Commissary Agreement

Name of mobile unit: ____

Name of operator / phone #: ____

Mobile unit owner: ____

Mailing address of owner: ____

City, State, Zip: ____

Phone number of mobile unit owner: ____

Title 410 IAC 7-24-113 of the Indiana State Department of Health Retail Food Establishment Sanitation Requirements states that all mobile food units must meet minimum requirements pertaining to water and food source, sewage and solid waste disposal, cleaning and servicing facilities and the renewal of supplies for mobile upkeep and must operate from a commissary that is revisited daily. In order to meet these requirements, a mobile unit operator may choose to make agreements with one or more provider as long as each meets the minimum requirements.

This form is to verify to the Harrison County Health Department that an agreement exists between the mobile unit operator and the provider and that the provider's facility is in compliance with the applicable requirements of the regulations.

I hereby certify that an agreement exists between:

____ and
Name of mobile unit

____
Name of commissary facility

__________________ _____, 20_____ to ____________________ _____, 20_____
Time period for commissary use - Month *Day* *Year* *Month* *Day* *Year*

to use my facility during the above stated time period and that my facility is in compliance with the regulations of 410 IAC 7-24-113 and will remain in compliance for the indicated time period.

Please indicate below what services are being allowed in your facility. (Example: warewashing, storage, food prep, wastewater disposal, etc.)

____

____

Signed: ________________________________ Title: ____________________________

Facility address / phone #: ____

Date: ______________________________