## Application for a Permit to Operate Allegany County Department of Health

A. Facility Information (Er	ntire section must be comp	leted by all applicants	s.)	
Facility		Phone		
			_	
Location (Town/Village)		County Allegany		
B. Operations Regulated	by this Permit			
Permitted Operation(s):	□ Food Service	-	• •	
	<ul><li>□ Frozen Dessert</li><li>□ Mobile Food Service</li></ul>		•	
Fee Exempt	Total Fee Due \$			
Capacity	_ Units: □ Seats	□ Rooms/Units	□ Persons	
	□ Sites	□ Swimmers	□ Beds	
In Operation: □ Year-Roun	d □ Seasonal □ Te	emporary		
Expected	Expected	Days of ☐ Sun ☐	Mon □ Tues □ Wed	
Opening date	Closing date am / pm TO	Operation:  ☐ Thur ☐	⊢Fri □ Sat □ Sun	
Hours of Operation	am / pm TO	am / pm		
Water Supply: □ Pul	blic (municipal) 🛚 Private (o	onsite)		
Sewage System: □ Pul	blic (municipal) □ Private (o	onsite)		
C. Operator / Owner Infor	mation			
(Check all that apply)				
	☐ Receives Mail ☐ Re	esponsible Person		
Legal <i>Operator</i> or operating	corporation	·		
	o, Section G must be complete	ted.)		
Title Person in Charge	<del></del>	Pho	ne	
Address			_	
			_	
	nber OR S			
		_	hone	
			hone	
From:				

D. Complete for temporary food service establishments only (attach additional paper if needed)										
Name of location of ev	/ent									
		er of ingredients	<del></del>	Where and how foods will be prepared and served			served			
		<u> </u>								
E. Complete for mobile food service establishments or pushcarts only.										
Type of Vehicle:	□ Moto	orized	□ Push	cart	□ Other (speci	ifv)				
Motor vehicle license	☐ Motorized ☐ Pushcart ☐ Other (specify)									
Commissary name	ense no. (for motorized vehicles)Phone									
Address										
		- <b>f f</b>				-				
List on separate shee	t types o	or rood and bev	erages	servea.						
F. Food and beverage machines only. Attach a list of all machine locations and food dispensed.										
G. Partners and Corporate Officers List all partners and cooperate officers in the operation of the facility. Include vice president(s), secretary, and treasurer. Attach DOH-2135 (or additional sheets) as necessary.  Name Title Address Phone										
<ul> <li>H. Workers' Compensation and Disability Insurance (All applicants must complete this section.)</li> <li>This is to certify, under penalties of perjury, that         <ul> <li>(A) the operation described in this application has Workers' Compensation and disability insurance as identified below:</li> </ul> </li> </ul>										
		Carrier			Policy No.	Expirat	ion Date			
Workers' Compensation	on				•	•				
Disability Benefits										
OR (B) □ a represen coverage is n			pensati	on Board h	as endorsed form	C-105.21 statir	ng that such			
	•									
I. Signature										
FALSE STATEMENT Failure to sign this for violation of the State S	m may	delay issuance								
Signature of individua	l operat	tor or authorized	d officia	I						
Drint name of server	olanic -					Title				
Print name of person	signing					Title	35 (8/05)			