

APPLICATION TO OPERATE A 6 MONTH FOOD SERVICE ESTABLISHMENT

Important please read!

*This application must be filled out completely and fees attached before your license will be processed. If it is not filled out completely, it will be mailed back to you.

**No license fees can be transferred between owners or establishments.

Vendor/Business Information:

Name of Vendor/Business: _____

Address: _____

Phone Number: _____ E-mail: _____

Water Supply: (✓ one) Public _____ Private Well _____

Sewer: (✓ one) Public _____ Private Septic _____

Manager/Person in Charge Name: _____

Manager/Person in Charge Phone Number: _____

Start Date: ____/____/____ End Date: ____/____/____

Hours of operation, or you may attach a schedule: *OT=Operating Times

✓ check all that apply

Mon. _____ OT Tues. _____ OT Wed. _____ OT Thurs. _____ OT

Fri. _____ OT Sat. _____ OT Sun. _____ OT

***Please attach a copy of the menu**

Menu Items	Source (where menu items/ingredients are purchased)

License Fees:

_____ Class 1A High Risk 6 MONTH \$472.00
 _____ Class 2A Medium Risk 6 MONTH \$392.00
 _____ Class 3A Low Risk 6 MONTH \$250.00

_____ Class NFP 6 Month-Not-for-Profit \$0.00 Tax Exempt # _____
 _____ High _____ Med _____ Low

*To assure timely permit processing, please submit permit application and payment **two weeks** before start date.

Initials of person filling out this form

Re-inspection Fees:

First Re-inspection Fee \$125.00
 Second Re-inspection Fee \$150.00
 Third Thru Fifth Re-inspection Fee \$200.00
 Sixth or more Re-inspection Fee \$300.00

Please turn over to complete →→→→→

IL Certified Food Service Manager Name	Identification Number	Expiration Date

2-102.12 Certified Food Protection Manager

(A) The PERSON IN CHARGE shall be a certified FOOD protection manager who has shown proficiency of required information through passing a test that is part of an ACCREDITED PROGRAM.

(B) This section does not apply to certain types of FOOD ESTABLISHMENTS deemed by the REGULATORY AUTHORITY to pose minimal risk of causing, or contributing to, foodborne illness based on the nature of the operation and extent of FOOD preparation. (Low Risk)

Owner Information:

Owner Name: _____

Owner Address: _____
City State

Phone Number: _____

Mailing/Billing Information:

"Below is the address that all of the mailings/billings from Sangamon County Department of Public Health are to go to. If at anytime this address changes, it is my responsibility to notify Sangamon County Department of Public Health."

_____ initials of person filling out form

Name of Person responsible for Receiving Billings & Mailings: _____

Mailing/Billing Address: _____
City

Phone Number: _____

By signing this application you are stating that all of the information on the front and back of this form is true and correct, and that if there are any changes to this information you are responsible for notifying the the Sangamon County Department of Public Health of the changes in a timely manner.

Signature of Applicant x _____ Date _____

For Official Use Only

Approving Authority: _____ Approval Date: ____/____/____

Director of Public Health: _____

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