

FOOD SERVICE LICENSE APPLICATION

Any License issued pursuant to this application will be subject to applicable State and Ledge Light Health District Food Establishment Regulations. Licenses are not transferable between owners. A name change requires a new application, even if ownership remains the same.

Year round Seasonal (6 months or less)

New Establishment Change in Ownership Change in FSE Name

Name of Establishment: _____

Address of Establishment: _____

Establishment Phone: _____

Email Address for Public Health Alerts: _____

Name of Owner of Establishment: _____

Address for Legal Notices (if different from above): _____

Phone Number of Owner: _____ Email of Owner: _____

24 hr Emergency Contact Number: (Cell phone preferred) _____

Name of Manager: _____ Phone: _____

Email Address: _____

<p>Type of Establishment</p> <p><input type="checkbox"/> Restaurant (sit down)</p> <p><input type="checkbox"/> Take Out Only</p> <p><input type="checkbox"/> Deli</p> <p><input type="checkbox"/> Convenience Store</p> <p><input type="checkbox"/> Grocery Store</p> <p><input type="checkbox"/> Bakery</p> <p><input type="checkbox"/> Healthcare Institution</p> <p><input type="checkbox"/> School</p> <p><input type="checkbox"/> Daycare</p> <p><input type="checkbox"/> Religious</p> <p><input type="checkbox"/> Caterer</p> <p><input type="checkbox"/> Club</p>	<p>Seating Capacity</p> <p>Indoor _____</p> <p>Outdoor _____</p> <p>Meals Served</p> <p><input type="checkbox"/> Breakfast</p> <p><input type="checkbox"/> Lunch</p> <p><input type="checkbox"/> Dinner</p>	<p>Water Supply</p> <p><input type="checkbox"/> Public</p> <p><input type="checkbox"/> Private (please provide most recent test)</p> <p>Note: The CT State Dept. of Public Health–Water supplies section regulates well water supplies for food service operations. An unregistered water supply serving a food service establishment must be screened by the CT DPH for classification as a public or private water source.</p>	<p>Hours of Operation</p> <p>Sun _____ to _____</p> <p>Mon _____ to _____</p> <p>Tues _____ to _____</p> <p>Wed _____ to _____</p> <p>Thurs _____ to _____</p> <p>Fri _____ to _____</p> <p>Sat _____ to _____</p> <p>If Seasonal, please indicate months in operation</p> <p>Opens: _____</p> <p>Closes: _____</p> <p>Note: If 6 months or less, may pay half of license fee</p>
<p>Grease Disposal</p> <p><input type="checkbox"/> Indoor Grease Trap <input type="checkbox"/> In-Ground Grease Trap</p> <p><input type="checkbox"/> AGRU <input type="checkbox"/> Grease Rendering Container</p>	<p>Sewage Disposal</p> <p><input type="checkbox"/> Public Sewer</p> <p><input type="checkbox"/> Private Septic System</p> <p>*If private, applicant shall discuss a B100a review with a land use sanitarian</p>		

Please check appropriate Classification (refer to attached Guidelines for Classifying Food Service Establishments sheet)

Class I Class II Class III Class IV

***All Class II, III & IV establishments shall have a Certified Food Protection Manager employed and a Person in Charge present whenever the facility is in operation. The Person in Charge shall also have a valid Certified Food Protection Manager Certificate**

Certified Food Protection Manager: _____

Approved Course Certification: ServSafe National Registry of Food Safety Prof., Inc
 Prometric 360Training.com

Person in Charge: _____

Approved Course Certification: ServSafe National Registry of Food Safety Prof., Inc Designate Alternate Form
(if required) Prometric 360Training.com (provide copy)

INCLUDE WITH YOUR COMPLETED APPLICATION:

__ Payment (Make checks payable to Ledge Light Health District.) *(There is a \$25 charge for all returned checks)* Fees can also be paid online at <http://pay.llhd.org/> or at our office with a credit card.

__ Copy of MENU

__ Copy of CFPM documentation if required

__ Copy of PIC/DA documentation if required

*By signing, the applicant agrees the above information is accurate and agrees to comply with all aspects of the State of Connecticut and Ledge Light Health District Food Service Regulations. **This is not a permit; permits will be issued by mail and are required to be posted in the establishment.***

Applicant Signature

Date

Please Print Name

Office Use Only:

Date Paid: _____ Check Number: _____ Cash: _____ Credit Card: _____ Receipt #: _____

Classification: _____ CFPM Approved: Yes No N/a

Final Approval: _____ Date License Issued: _____
(Director of Health or Authorized Agent)