

## **Instructions for Completing the Permanent Food Service Facility License Application**

**Please complete the entire application to apply for a permanent food service facility license from the Anne Arundel County Department of Health. The information listed below corresponds to the items listed on the Application.**

**Facility Name & Address:** Write the facility name and address.

**Facility Phone Number:** Indicate the telephone number at the facility.

**Business Owner:** Should be the legal tax name. If you are incorporated or corporate, write the name of corporation.

**Mailing Address:** Indicate the address where you want to receive business correspondence.

**Business Owner Phone Number:** Indicate a telephone number other than at facility. (e.g. private number, cell phone number).

**Property Owner:** If property owner is known, indicate name, address and phone number. If not known, indicate management company name, address and phone number.

**Corporate Officer or Resident Agent:** Indicate names, addresses and phone numbers of corporate or business officer(s) or resident agent of this facility.

**Property Tax Account Number:** Obtain from owner or your management company. PLEASE PROVIDE. THIS INFORMATION IS ESSENTIAL FOR OUR RECORD KEEPING SYSTEMS.

**Federal ID Number:** Indicate number issued to business owner by Internal Revenue Service.

**Food Service Types:** Indicate whatever applies to your business. If seasonal business, indicate the dates of operation.

**Water:** Indicate whether you are on public water or on private well. (**NOTE:** If on private well, certified laboratory testing is required, and results must be submitted to this department).

**Sewer:** Indicate whether you are on public sewer or on a septic system.

**Grease Trap or Recovery:** Indicate whether you use a grease trap (which is a tank located outside building in ground) or a grease recovery unit (electrical box usually located under the three compartment sink).

**Seating:** Indicate whether you have seating or not. If so, indicate the number of seats.

**Smoking Prohibited:** Indicate whether you prohibit smoking in all indoor areas and post no smoking signs.

**Days and Hours of Operation:** Indicate days of the week and appropriate times for those days of operation (e.g. Sunday 10 a.m. – 4 p.m., Monday - Saturday 8 a.m. – 6 p.m.).

**NOTE:** Please sign and date application. Below signature line, print the applicant's name, address, phone number and date application.

**ALL CHECKS ARE PAYABLE TO CONTROLLER, ANNE ARUNDEL COUNTY.**

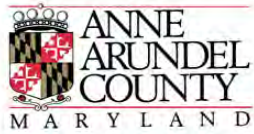
Send or bring this application, proof of Workmen's Compensation Insurance (or a certificate of eligibility) and all appropriate fees (see bottom right corner of application) to the address located at the top of the application. Please contact this office if you require assistance in determining correct fees.

Plans for new food service facilities should be sent or brought with the application and plan review fee to the Permit Application Center, Heritage Center, 2664 Riva Road, Annapolis, MD 21401.

**PLEASE NOTE: LICENSE EXPIRES FEBRUARY 28<sup>TH</sup> OF EACH YEAR.**

**For more information contact:**      **Housing and Food Protection  
Bureau of Environmental Health  
Anne Arundel County Department of Health  
3 Harry S. Truman Parkway  
Annapolis, Maryland 21401  
410-222-7238**

**Revised 7/10**



**FOOD SERVICE FACILITY - LICENSE APPLICATION  
HOUSING & FOOD PROTECTION SERVICES  
BUREAU OF ENVIRONMENTAL HEALTH  
ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH  
3 HARRY S. TRUMAN PARKWAY  
ANNAPOLIS, MARYLAND 21401  
(410) 222-7363**

**PERMANENT FACILITY**

(PLEASE PRINT)

FACILITY NAME: \_\_\_\_\_

FACILITY ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ FACILITY PHONE NUMBER: \_\_\_\_\_

BUSINESS OWNER: \_\_\_\_\_ BUSINESS OWNER'S E-MAIL: \_\_\_\_\_

MAILING ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ BUSINESS OWNER'S PHONE NUMBER: \_\_\_\_\_

PROPERTY OWNER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

CORPORATE OFFICERS OR RESIDENT AGENTS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

PROPERTY TAX ACCOUNT #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ FEDERAL ID#: \_\_\_\_\_

**FOOD SERVICE TYPES:**

- |                                      |  |   |  |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> BAKERY      | <input type="checkbox"/> CATERING                            | <input type="checkbox"/> RESTAURANT     | <input type="checkbox"/> INSTITUTION       |
| <input type="checkbox"/> CAMP        | <input type="checkbox"/> GROCERY                             | <input type="checkbox"/> CAFETERIA/DELI | <input type="checkbox"/> CONVENIENCE STORE |
| <input type="checkbox"/> TAVERN      | <input type="checkbox"/> CARRY-OUT                           | <input type="checkbox"/> SCHOOL         |  |
| <input type="checkbox"/> OTHER _____ | <input type="checkbox"/> SEASONAL (Dates of Operation) _____ |   |  |

WATER:  PUBLIC  PRIVATE GREASE TRAP:  YES  NO SEATING:  YES  NO  
SEWER:  PUBLIC  PRIVATE GREASE RECOVERY:  YES  NO DEFINE NO. OF SEATS: (    )

DO YOU PROHIBIT SMOKING IN ALL INDOOR AREAS OPEN TO THE PUBLIC? \_\_\_\_\_

ARE SIGNS POSTED PROHIBITING SMOKING? \_\_\_\_\_

DAYS AND HOURS OF OPERATION: \_\_\_\_\_

ISSUANCE OF THIS LICENSE/PERMIT IS CONDITIONED ON THE APPLICANT'S CONSENT TO INSPECTIONS; THAT SUCH INSPECTIONS WILL FOCUS ON DETERMINING LICENSEE'S/PERMITEE'S COMPLIANCE WITH THE LAWS AND REGULATIONS RELATED TO THE LICENSE/PERMIT; THAT INSPECTIONS WILL BE CONDUCTED AT REASONABLE TIMES UNLESS THE HEALTH OFFICER HAS REASON TO BELIEVE THAT VIOLATIONS ARE OCCURRING THAT CAN ONLY BE DETECTED AT OTHER TIMES; THAT FAILURE TO ALLOW INSPECTIONS MAY RESULT IN SUSPENSION OR REVOCATION OF THE LICENSE/PERMIT, IN ADDITION TO ALL OTHER REMEDIES PERMITTED BY LAW.

APPLICANT SIGNATURE/TITLE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME & ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

|                            |
|----------------------------|
| <b>FOR OFFICE USE ONLY</b> |
| AREA: _____                |
| HACCP PRIORITY: _____      |
| ID#: _____                 |
| DATE APPROVED: _____       |
| INSPECTOR: _____           |

|  |          |
|--|----------|
| <u>      </u> <b>NEW</b> <u>      </u> <b>RENEWAL</b> <u>      </u> <b>CHANGE OF OWNERSHIP</b> |          |
| <input type="checkbox"/> HIGH/PRIORITY   | \$590.00 |
| <input type="checkbox"/> MODERATE PRIORITY   | \$395.00 |
| <input type="checkbox"/> LOW PRIORITY  | \$195.00 |
| <input type="checkbox"/> HIGH/PRIORITY <4 months   | \$395.00 |
| <input type="checkbox"/> MODERATE PRIORITY <6 months   | \$195.00 |
| <u>      </u> <b>STRUCTURAL PLAN REVIEW</b>  |          |
| <input type="checkbox"/> HIGH/PRIORITY   | \$750.00 |
| <input type="checkbox"/> MODERATE PRIORITY   | \$750.00 |
| <input type="checkbox"/> LOW PRIORITY/STATE  | \$500.00 |
| <u>      </u> <b>HACCP PLAN REVIEW</b>   |          |
| <input type="checkbox"/> HIGH PRIORITY   | \$750.00 |
| <input type="checkbox"/> MODERATE PRIORITY   | \$750.00 |
| <input type="checkbox"/> STATE HACCP PLAN REVIEW   | \$750.00 |
| <u>      </u> <b>EXEMPT</b>  | \$0.00   |