CHRISTIAN COUNTY
HEALTH DEPARTMENT
Show them healthy.

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Christiancountyhealth.com

2016 RENEWAL FOR FOOD ESTABLISHMENT PERMIT

OWNER INFORMATION

Owner Name: (Please Print)		
Mailing Address:		
City:	State:	ZIP Code:
LLC DBA Corporation (Please	Phone:	Fax:
Email Address: **(required)**		

ESTABLISHMENT INFORMATION

Name of Establishment:			
Physical Address:			City:
State:	ZIP Code:	Phone:	Fax:
E-mail: **(required)**			

Please choose one:	❑ Restaurants (see below) ❑ Food Service (no seating or seating < 26) $50.00	❑ Retail or Convenience $50.00	❑ School Call for fee information	❑ Sr. Center (exempt)	❑ Mobile $50.00	❑ Other

If Restaurant, what is the seating capacity of the facility? _____ **multiply # of seating by 2 for fee /$50.00 minimum.**

What are your Hours and Days of Operation?

Do you have an emergency generator for power? ❑ Yes ❑No

Have you remodeled, expanded, or changed ownership in the last year? ❑Yes ❑No

CURRENT CERTIFIED FOOD MANAGERS/HANDLER(S)-MUST HAVE ONE *CERTIFIED FOOD MANAGER* ON DUTY AT ALL HOURS OF OPERATION

Name	Brand Name of – **Food Protection Manager**	Expiration date

If more space is needed for Certified Food Manager/Handlers, please attach separate list.

All food items must be from an approved/inspected source. If you intend to make changes (i.e.: additional menu items, remodel, or expansion) you must inform CCHD prior to these changes. Permit is subject to revocation if any changes made are found to be noncompliant with the current Missouri Food Code.

I, THE UNDERSIGNED, ATTEST ALL INFORMATION IN ABOVE IS ACCURATE:

Printed Name of Applicant	
Signature of Applicant	Date

Health Department Use Only

EPHS Approval:		Date:
Supervisor Approval:		Date:
Risk Assessment Assigned:	Date:	Permit # 2016-
Date Received:	Amount:	
Cash/Check #:	Receipt #:	