Application Type:
__New
__Change of Ownership
__ Renewal

Charles County Department of Health
Division of Environmental Health Services
4545 Crain Highway/P.O. Box 1050
White Plains, MD 20695
301-609-6751 Fax: 301-609-6684

Official Use:
Amount Due: _____
Date Paid: _____
Priority: _____
HACCP Approval Date: _____

Application to Operate a Food Service Establishment

Application is hereby made to operate a food establishment in accordance with Health-General, §305, Annotated Code of Maryland. The license application fee of **$50** for excluded organizations*, **$160** for low priority, **$540** for moderate priority, and **$600** for high priority food establishment renewals and change of ownerships is due at the time of application. Fees for new facilities are pro-rated and are due prior to issuance of the license to operate. Fees are payable to the "Charles County Department of Health". All food service establishment licenses expire December 31st of each year. Renewal applications must be received by the Department prior to the expiration date of the license. Please complete this application entirely. Incomplete applications will be returned.

FACILITY CONTACT INFORMATION

Business Name:	Establishment Name (T/A):
Establishment Physical Address:	Establishment Mailing Address:
Establishment Telephone #:	Establishment Fax #:
Business Owner's Name/Corporation Name:	Business Owner's Name/Corporation Mailing Address:
Business Owner's Name/Corporation Telephone #:	Contact Person Name:
Contact Person Telephone #:	Contact Person Fax #: Contact Person Email Address:
Former Name of Business (Change of Ownership Only):	Tax ID # (FEIN):

PROPERTY INFORMATION

Property Owner's Name:	Property Account ID#:	
Property Owner's Telephone #:	Water Supply: ____Private ____ Public	For "private" wells, does the facility serve 25 or more patrons per day for more than 60 days per year? ____ Yes _____ No
Property Owner's Mailing Address:	Sewage Disposal: ____Private ____ Public	
	Grease Trap Installed: _____ Yes _____ No If yes, capacity: _____ gallons	

FACILITY INFORMATION

Type of Facility (check all that apply):

___ Restaurant	___ Caterer (Private Events)	___ Grocery/Food Mart	___ Hospital
___ Carry Out	___ Caterer (Public Events)	___ Excluded Organization	___ Adult Daycare
___ Institution	___ Mobile Unit	___ Liquor Store	___ Processing
___ School	___ Commissary Kitchen	___ Nursing Home	Other:_____

Hours of Operation: _____Days of Operation: _____

Months of Operation: _____ Liquor License: ___Yes ___No

Patrons Served per Day: _____ Number of Employees: _____ Number of Seats: Indoor _____ Outdoor _____

Certified Manager (if applicable): _____Cert. Expiration: _____

Source(s) of Food (name of suppliers):

_____

_____

Food Processes (check all that apply):

___ Process 1 (commercially packaged potentially hazardous food / hand dipped ice cream)

___ Process 2 (cook-serve / cook-hot hold serve / cold hold-serve)

___ Process 3 (cook-hot hold-cool-serve / cook-hot hold-cool-reheat-serve / cook-cool-cold hold-serve / cook-cool-reheat-serve)

___ Special Processes (specify): _____

Mobile Units:

Make: _____ Model: _____

Tag#: _____ VIN: _____

Special Markings: _____

Commissary Location:

_____

Cold Holding by: ___ Mechanical Refrigeration ___ Ice

*__Excluded Organizations__ (bonafide nonprofit civic, fraternal, war veterans', religious, or charitable organization/corporation not serving food for more than 4 days per week):

Tax Exempt #: _____

Commercial Equipment: ___ Yes ___ No

By signing this application, you acknowledge that licensure of an excluded organization meeting the above provisions is voluntary. However, once a decision is made for licensure, the decision is non-rescindable.

By signing this application, you acknowledge that you have read this application completely and will comply with all applicable provisions in federal, state, and local laws, regulations, and ordinances. Failure to comply and/or correct violations may result in licensure suspension, revocation, or denial. I understand that falsification of this application may result in denial, suspension, or revocation of the license.

_____

Owner's Signature

Worker's Compensation Insurance Information:

Worker's Compensation Insurance: __ Yes __ No
If "yes": Carrier Name _____
Binder #: _____

If "no", please specify reason (exempt, sole proprietor):
_____

Official Use:
Application Approved By (signature): _____