

CHESPROCOTT HEALTH DISTRICT

1247 HIGHLAND AVENUE, CHESHIRE, CT 06410

Phone: (203) 272-2761

Maura Esposito, R.S., M.P.H., Director of Health

Fax: (203) 250-9412



APPLICATION FOR FOOD SERVICE LICENSE ONE FORM FOR EACH ESTABLISHMENT

COMPLETE ALL SECTIONS OF THIS APPLICATION

FAILURE TO DO SO WILL DELAY THE ISSUING OF THE LICENSE

RETURN WITH PAYMENT OF \$ _____ OR TAX EXEMPT # _____

NAME OF ESTABLISHMENT _____

STREET / TOWN / ZIP _____

_____ New Establishment _____ Annual Renewal

_____ Catering Also _____ Change of Ownership

_____ Number of Seats (Including Bar Seats)

CHD in Office Use Only Category _____ Class _____

< PLEASE PRINT CLEARLY AS YOU ENTER THE INFORMATION REQUESTED >

Mailing Address, if different from above _____

Business phone _____

Business Fax Number _____

Manager's Home phone _____

Manager's Cell Phone _____

Email Address _____

Name and Address of Food Service Owner(s) (Include Street, City, State & Zip)

Name and address of Manager, if different from above

Name(s) of Qualified Food Operator(s) {QFO}, if applicable

Name and address of landlord, if applicable

AUTHORIZED SIGNATURE OF FOOD SERVICE OWNER _____