



Eastern Highlands Health District

4 South Eagleville Road • Mansfield CT 06268 • Tel: (860) 429-3325 • Fax: (860) 429-3321 • Web: www.EHHD.org

FOOD SERVICE LICENSE APPLICATION

- New Establishment
- Transfer of Ownership (See FSE Ownership Transfer Screening Form)
- Itinerant Food Vendor (See Itinerant Food Vendor Information Form)

Name of Establishment _____

Location _____ Town _____

Establishment Mailing Address _____

Town _____ State _____ Zip Code _____

Establishment Phone _____ Establishment Fax _____

Email Address _____

Owner of Establishment _____

Owner Mailing Address _____

Town _____ State _____ Zip Code _____

Owner Home Phone (for EHHD use only) _____

Manager of Establishment _____

Manager Home Phone (for EHHD use only) _____

Corporation/Business Name(if applicable) _____

Corporation/Business President/CEO _____

Mailing Address _____

Town _____ State _____ Zip Code _____

Corporation Phone _____ Corporation Fax _____

Revised 5/15/2008

PLEASE COMPLETE OTHER SIDE OF FORM

PLEASE FILL OUT ALL SECTIONS BELOW

Type of Establishment

- Mobile/Itinerant Vendor
- Restaurant
- Deli/Convenience Store
- Grocery Store
- Caterer
- Bakery
- Healthcare Institution
- Church/Organization
- School/Daycare
- Other _____

Seating Capacity _____

Service Method (Check All That Apply)

- Buffet/Salad Bar
- Take Out
- Catering
- Sit Down (Indoor/Outdoor)

Hours of Operation (when are you open?)

Mon _____ Tues _____
 Wed _____ Thurs _____
 Fri _____ Sat _____
 Sun _____

If Seasonal Use:

Indicate Months of Operation

_____ to _____

Sewage Disposal

- Public Sewer
- Septic System

Grease Trap

- Indoor
- Outdoor
- None

Water Supply

- Community
- NTNC
- TNC
- NOT REGISTERED WITH DPH*(see below)
- Itinerant Source _____

Water Treatment

- Yes
- No

*With a water supply serving the public, you are required to submit a Water Quality Report with this application. All water samples must be taken by a **qualified individual** and tested by a certified laboratory.

FOR CLASS 3 & 4 FOOD SERVICE ESTABLISHMENTS, COMPLETE THE FOLLOWING:

Name of Qualified Food Operator (QFO) _____

Approved Test Course _____

The QFO shall be onsite, in a supervisory position with authority, responsible for training all personnel ensuring safe food handling practices and compliance with CT Public Health Code Section 19-13-B42.

Name(s) of Alternate QFO(s) _____

Approved Test Course _____

The designated alternate shall act in the position of QFO, when the above listed QFO cannot be present.

**YOU MUST SUBMIT A COPY OF THE QFO COURSE CERTIFICATE
BEFORE LICENSE WILL BE ISSUED**

THE UNDERSIGNED AGREES TO COMPLY WITH THE EHHD SANITARY CODE AND THE CT PUBLIC HEALTH CODE. FOR DUE CAUSE, THIS LICENSEE MAY BE SUSPENDED BY THE DIRECTOR OF HEALTH.

Authorized Signature _____ **Date** _____

FOR OFFICE USE ONLY

Establishment No. _____ Class _____ License Fee Due _____

Date Payment Received _____ Check/MO No. _____