Permit to Operate
Food Service Application

Niagara County Department of Health

Business / Location Information

Business Name _____

Address _____ **Business Phone** _____

_____ **Business Fax** _____

Location _____ **Business Website** _____

County *NIAGARA* **Business Email** _____

Operator Mailing Address:

Permit Number

Permit Expiration Date

Total Fee Due $

Permitted Operation

Food Service Establishment: **Operation ID:**

In Operation: ☐ Year-Round ☐ Seasonal **If Seasonal:** Expected Opening Date _____ (Month/Day) Expected Closing Date _____ (Month/Day)

Capacity: _____ Days/Hours of Operation: _____ / _____

Permit Applicant Information

Legal Operator or Operating Corporation:

Person in Charge _____ (Title) _____ (First) ____ (MI) _____ (Last)

Operator Address _____

City, State, Zip _____ *NY* _____

Primary Phone _____ Ext _____ ☐ Cell Fax _____ *Emergency Contact* ☐

Other Phone _____ Ext _____ ☐ Cell E-mail _____

Location Owner: _____

Address _____

City, State, Zip _____ *NY* _____

Primary Phone _____ Ext _____ ☐ Cell Fax _____ *Emergency Contact* ☐

Other Phone _____ Ext _____ ☐ Cell E-mail _____

Permit to Operate
Renewal Application

Niagara County Health Department

Workers' Compensation and Disability Insurance

Submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law:

A. Workers Compensation and Disability Insurance Coverage is PROVIDED

Workers Compensation

Form C-105.2 – Certificate of Worker's Compensation Insurance **OR**

Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

AND

Disability Benefits

DB-120.1 - Certificate of Disability Benefits **OR**

Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage is NOT PROVIDED

Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

Return Completed Application

Please return completed application to:

Make checks payable to "Niagara County Department of Health" and include the permit number.

Niagara County Department of Health
Environmental Health Division
55 Stevens Street
Lockport NY 14094

Phone: (716) 439-7444 Fax: (716) 439-7427

Signature of Individual Operator or Authorized Official (Entire section must be completed by all applicants.)

I would like to receive information and official correspondence related to this permit at the email address below: (Yes ◉ No ○)

_____ @ _____

"Operation without a valid permit is a violation of New York State Law and/or State Sanitary Code."

Signature _____

Print Name _____ Title _____ Date _____

FOR OFFICE USE ONLY

Permit issuance recommended? ☐ Yes ☐ No Permit Effective Date _____ Permit Expiration Date _____

Conditions of approval _____

Signature _____ Title _____ Date _____