Permit to Operate Food Service Application

Niagara County Department of Health

Business / Loc	ation Information	1						
Business Name								
Address				Business Pho	one			
				Business Fax	<u> </u>			
Location				Business We	bsite			
County NIAG	ARA		_	Business Em	ail			
Operator N	Mailing Address:				Permit Number			
					Per	mit Expiration Date		
					Total	Fee Due \$		
Permitted Operation	Food Service Establishment:				Operati	ion ID:		
In Operation:	Year-Round	Seasonal	If Seasonal:	Expected Openi	ing Date	Expected Closing Date		
Capacity:	Days/Hours of Operation:/							
Permit Applica	ant Information							
Legal Operat	tor or Operating	Corporation:						
Person in Charge	•							
	Title	First			MI Last			
Operator Address	<u> </u>						_	
City, State, Zip			<u>NY</u>					
Primary Phone		Ext		ell Fax		Emergency Contact		
Other Phone		Ext		ell E-mail				
Location Ov	vner:			_				
Address								
City, State, Zip			VY				_	
Primary Phone		Ext		Cell Fax		Emergency Contact		
Other Phone		Ext		Cell E-mail				

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Niagara County Health Department

Workers' Compensation and Disability	/ Incurance			
Submit copies of the following document	tation with the application to document comp	liance with the Worker's Compensation Lav	۸/۰	
·	ility Insurance Coverage is PROVIDED	mance with the Worker's Compensation Lav		
Workers Compensation	my modulatice doverage is i novibed			
	of Worker's Compensation Insurance	OR		
	f Workers' Compensation Insurance	OR		
	Workers' Compensation Self-Insurance	OR		
	Participation in Workers' Compensation Gro	• • • • • • • • • • • • • • • • • • • •		
AND				
Disability Benefits				
DB-120.1 - Certificate of Dis	OR			
Form DB-155 – Certificate of	of Disability Benefits Self-Insurance			
B. Workers Compensation and Disab	ility Insurance Coverage is NOT PROVIDE	D		
Form CE-200 – Certificate of	of Attestation of Exemption from NYS Worker	rs' Compensation and/or Disability Benefits	Coverage	е
Detrum Commisted Application				
Return Completed Application				
Please return completed application to	January - opinion			
Make checks payable to "Niagara	Environmental Health Divis	ion		
County Department of Health" and include the permit number.	5467 Upper Mountain Road	, Suite 100		
include the permit number.	Lockport NY 14094-1894			
	(716) 439-7444	Fax: (716) 439-7427		
Signature of Individual Operator or Au	thorized Official (Entire section must	be completed by all applicants.)		
Signature of Individual Operator or Au I would like to receive information and of	•		No)
I would like to receive information and of	ficial correspondence related to this perr	mit at the email address below: (Yes	No)
I would like to receive information and of	ficial correspondence related to this perr		No)
I would like to receive information and of	ficial correspondence related to this perr	mit at the email address below: (Yes	No)
I would like to receive information and of	ficial correspondence related to this perr	mit at the email address below: (Yes	No)
I would like to receive information and of "Operation without a valid permit is a v Signature	ficial correspondence related to this perr	mit at the email address below: (Yes)
I would like to receive information and of "Operation without a valid permit is a v Signature	ficial correspondence related to this perr @ riolation of New York State Law and/or S	mit at the email address below: (Yes)
I would like to receive information and of "Operation without a valid permit is a v Signature Print Name FOR OFFICE USE ONLY	ficial correspondence related to this perr @ violation of New York State Law and/or S	mit at the email address below: (Yes		
I would like to receive information and of "Operation without a valid permit is a v Signature Print Name FOR OFFICE USE ONLY Permit issuance recommended?	ficial correspondence related to this perr @ violation of New York State Law and/or S	State Sanitary Code." Date		
I would like to receive information and of "Operation without a valid permit is a v Signature Print Name FOR OFFICE USE ONLY	ficial correspondence related to this perr @ violation of New York State Law and/or S	State Sanitary Code." Date		

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Signature ______ Title ______ Date _____