# Application for a Permit to Operate

**Complete all the items that apply to your establishment (all applicants must complete Sections A, B, D and E), sign on the back page and return with the appropriate fee at least 30 days prior to the expected opening date to:**

**Orange County Department of Health**
**124 Main Street**
**Goshen, N.Y. 10924**
845-291-2331

******Initial Permit Applications needing or requesting review/processing within 5 business days of our receipt shall be subject to a $100 expedited processing fee or $200 expedited processing fee if within 2 business days of our receipt (including those normally exempt from fees).******

If you have any questions, please contact the above.

**Section A: Facility Information (Entire section must be completed by all applicants.)**

Facility name ______________________________

Facility address ______________________________

City ________________ State ________ Zip _______ Telephone no. (____)_______ E-Mail ________________

**Municipality** ______________________________ **Capacity** _______ **Facility Status-**Profit ___Non-Profit___

**Water Supply**
___ Public (Municipal)
___ Private (onsite)

**Sewage System**
___ Public (municipal)
___ Private (onsite)

**Number of operation(s) under this registration**
___ Indoor Pools
___ Outdoor pools
___ Spa Pools
___ Day Camps
____ Bathing Beaches
____ Food Service
____ Frozen Desserts

**Indicate days of operation by checking the appropriate boxes.**

Expected Opening date_________ Month/Day
Expected Closing date ________ Month/Day
_____________ S M T W T F S
Hours of operation ____AM/PM Open ______ AM/PM Close

**Section B: Operator/Owner Information (Entire section must be completed by all applicants.)**

Legal **operator** or operating corporation ______________________________
(If corporation or partnership, Section C must be completed.)

<u>**MAIL CORRESPONDENCE TO:**</u>

Person in charge ______________________________

Permanent mailing address ______________________________

City ________________ State ______ Zip ________ Telephone no. (_____)______________

**Employer Identification Number** ___________________ or **Social Security Number** _____________

**Owner** ______________________________

Permanent address ______________________________

City ________________ State _________ Zip ________ Telephone no. (___)___________

**Section C: Partners and Corporate Officers**

List all partners and corporate Officers in the operation of the facility. Include vice president(s), secretary, treasurer. Attach additional sheets as necessary.

| Name | Title | Address | Telephone no. |
|---|---|---|---|
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**Section D: Must be completed by all applicants**
**WORKERS' COMPENSATION AND DISABILITY INSURANCE COVERAGE**
**Check the appropriate lines and submit copies of the appropriate documentation with the application to document compliance with the Workers' Compensation Law:**
A. Workers' Compensation and Disability Insurance Coverage **Provided**
Workers' Compensation
____ Form C-105.2 -Certificate of Workers' Compensation Insurance (From your insurance carrier) **OR**
____ Form U-26.3 -Certificate of Workers' Compensation Insurance (From the State Insurance Fund) **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 Insurance
____ DB 120.1 -Certificate of Disability Benefits (From your insurance carrier **OR**
____ Form DB 155 -Certificate of Disability Self Insurance

B. Workers' Compensation and Disability Insurance Coverage **NOT PROVIDED**
____ Form CE-200-Certification of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage
**APPLICATIONS WILL NOT BE PROCESSED NOR A PERMIT ISSUED WITHOUT WC/DB DOCUMENTATION**

**Section E: Signature (Entire section must be completed by all applicants)**

**FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW**
**Failure to sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code.**

Signature of individual operator or authorized official ____________________________________________

Print name of person signing _______________________________ Title ____________________ Date ____

**Section F: FOR OFFICE USE ONLY**
Permit issuance recommended? Yes ____ No _____ Permit Effective Date ________ Permit expiration Date _____
Conditions of approval ________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
Signature ______________________________ Title ______________________________ Date ___________________