ORANGE COUNTY DEPARTMENT OF HEALTH
124 MAIN STREET
GOSHEN, NEW YORK 10924

FOOD SERVICE CATERING COMMISSARY APPLICATION

_____20 _____

Under the provisions of Subpart 14-1 of the New York State Sanitary Code, application is hereby made for a permit to operate a permit to operate a catering commissary concerning which the following information is submitted:

Name of Commissary: _____

Location: _____

Mailing Address: _____

Daytime Telephone Number: _____ E-Mail: _____

Name of Operating Person*: _____

Address: _____

Owner of Food Service Establishment: _____

Address: _____

A fee of $300.00 is required for all commissaries.
******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).******

Either a check or money order should be made out to the Orange County Department of Health and must accompany this application.
I acknowledge that I have received a copy of Subpart 14-1 of the New York State Sanitary Code. If a permit is granted me for the operation of the above described food service establishment, I promise to faithfully observe all of its requirements.

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 C105.2 -Certificate of Workers' Compensation Insurance (Your insurance carrier) **OR**
____ Form U26.3 -Certificate of Workers' Compensation Insurance (State Insurance Fund) **OR**
____ Form SI-12 -Certificate of Workers' Compensation Self Insurance **OR**
____ GSI-105.2 -Certificate of Participation in Workers' Compensation Group Insurance

AND

Disability Insurance

____ DB 120.1 -Certificate of Disability Benefits (Your insurance carrier) **OR**
____ Form DB-155 -Certificate of Disability Benefits 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 Coverage

APPLICATIONS WILL NOT BE PROCESSED NOR A PERMIT ISSUED WITHOUT WC/DB DOCUMENTATION

_____ _____
Print Name of Person Signing Date

_____ _____
Signature of Official Operating "Person" Title of Position
(officer when operating "person" is a Corporation or Association)

*As defined in the State Sanitary Code, a "person" shall mean an individual, or firm, estate, partnership, company, corporation, trustee, association, or any public or private entity.