ORANGE COUNTY DEPARTMENT OF HEALTH, 124 MAIN STREET, GOSHEN, NY 10924
NON COMMERCIAL FOOD SERVICE ESTABLISHMENT PERMIT APPLICATION

Name of Establishment: _____

Former Name if different from above: _____

Circle if for: New Facility Application Renewal Change of Operator

Location: _____
Street municipality state zip

Type: _____Daytime Tel. #: _____ E-Mail: _____

Seating Capacity: _____

Circle if operating person is: CORPORATION ASSOCIATION PARTNERSHIP OTHER

LIST OPERATING PERSON CIRCLED ABOVE: _____

MAILING ADDRESS: _____
Street municipality state zip

Individual in charge of Food Service Operations: _____
Daytime Telephone Number: _____

Owner of Food Service Establishment: _____

Address: _____

Frozen Dessert (soft serve ice cream, snow cones, slush puppies etc.) manufactured _____yes _____no

A fee of $25.00 is required if frozen desserts are manufactured and served in addition to other foods. Either a check or money order should be made payable to the Orange County Department of Health and must accompany this application
******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).******

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 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 Benefits Coverage

If a permit is granted me for the operation of the above described food service establishment, I promise to observe faithfully all of the requirements of Subpart 14-1 of the New York State Sanitary Code.

_____ _____
Print Name of Person Signing Date

_____ _____
Signature of Official Operating "Person" (officer when operating "person" is a corporation association) Title of Position

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