



COMMONWEALTH OF VIRGINIA
RICHMOND CITY HEALTH DISTRICT
400 East Cary Street, Suite 322
Richmond, VA 23219 (804) 205-3912 FAX (804) 371-2208



"Working together for a healthier Richmond"

APPLICATION FOR FOOD ESTABLISHMENT PERMIT *PLEASE FILL OUT APPLICATION IN ENTIRETY*

OPERATION TYPE: Full Service Fast Food Carry-out Caterer Hospital School
 Concession Daycare Mobile Unit Other (please explain) _____

APPLICATION INFORMATION New Establishment Name Change Change of Ownership Renewal

Establishment Name: _____

Street Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

Legal owner type: Corporation LLC Association Partnership Individual or Other Legal Entity:

Legal Owner Name: _____

Street Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

Local registered agent (required for out of State Corporations - must identify registered agent for Virginia)

Registered Agent Name: _____

Street Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

Billing/Mailing Address:

Name: _____

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

PERSON DIRECTLY RESPONSIBLE FOR THE ESTABLISHMENT (ie: Manager, Executive Chef, Food Service Director, etc.)

Primary Contact Person Name: _____ Title: _____

Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

IMMEDIATE SUPERVISOR OF THE PERSON DIRECTLY RESPONSIBLE FOR THE ESTABLISHMENT

Name: _____ Title: _____

Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____ E-Mail Address: _____

TURN PAGE OVER TO COMPLETE APPLICATION

Name(s) of Certified Food Manager(s): _____ Certificate Exp. date: _____

PLEASE ATTACH A COPY OF CERTIFICATE

Will this be? Stationary Facility or Mobile Unit? VIN# _____ (**mobile units only**)

Seating Capacity: _____ Hours of Operation: Open _____ AM/PM Close _____ AM/PM - M T W T F Sa Su

Smoking Status: Smoke Free Outdoor Smoking Area Smoking in Designated Area Exempt

Method of solid waste disposal: Public Commercial Type: _____ Number of pick-ups per week: _____

WILL THIS FACILITY? (CHOOSE YES OR NO)

1. Prepare, offer for sale or serve food products that require time/temperature control? (i.e.: meat, dairy, seafood, poultry, cooked vegetables)
 - a. Only when the customer orders the food? Yes No
 - b. In large quantities to serve at a later time? Yes No
 - c. Use time as a public health control: (place food out at room temperature for a period of time) Yes No
2. Offer food on the menu that requires two or more steps which could include cooking, cooling, reheating, freezing, thawing, hot or cold holding? Yes No
3. Prepare food as identified in #2 that would be transported to another location? (catering) Yes No
4. Prepare food for a highly susceptible population? (i.e.: preschool aged children, older adults, persons who are immunocompromised and where custodial care is provided) Yes No
5. Prepare only food that is not a time/temperature control of safety food? Yes No
6. Offer for sale only prepackaged food that is not time/temperature control for safety food? Yes No

****PLEASE ATTACH MENU****

By signing this statement you attest to the accuracy of the information provided in the application, agree that you will comply with Section 12 VAC 5-421-3750, (12 VAC 5-421 Commonwealth of Virginia Board of Health Food Regulations) and allow the regulatory authority access to the establishment as specified under 12 VAC 5-421-3820 and to the records specified under 12 VAC 5-421-440 and 12 VAC 5-421-2330 and subdivision 4 of 12 VAC 5-421-3630

SIGNATURE REQUIRED

Applicant Name: _____ Title: _____

Applicant Address: _____

City: _____ State: _____ Zip Code: _____

Applicant Signature: _____ Date: _____

FOR OFFICIAL USE ONLY

Tax Map#:		GPIN:	Census Tract:
Processing Fee:		Date:	Receipt#:
Plan Review Fee:		Date:	Receipt#:
<input type="checkbox"/> Check	<input type="checkbox"/> Cash	<input type="checkbox"/> Credit Card:	Received by:
Permit Issued Date:		Issued by:	Expiration Date Updated by:
Approved for Permit (Y or N):		Sign by:	Date:
Risk Categorization Entered in EHD? <input type="checkbox"/> Yes <input type="checkbox"/> No Category # 1 2 3 4			
Date Reviewed:		Supervisor/Manager Signature	



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NAME OF COMMISSARY: _____

NAME OF MOBILE UNIT OR CATERING BUSINESS: _____

ADDRESS: _____ CITY: _____ ZIP CODE: _____

NAME OF FACILITY OWNER (Commissary) PLEASE PRINT: _____

NAME OF MOBILE UNIT OWNER/CATERER: _____

STATEMENT OF INTENT AND UNDERSTANDING

I/We have read and understand and agree to the rules and regulations governing mobile food units, caterers and commissaries. Knowing these conditions and provided health requirements are met, permission is granted to:

COMMISSARY OWNER/OPERATOR (Signature) _____

Signature _____ Date _____

MOBILE UNIT/CATERER OWNER OPERATOR (Signature) _____

Signature _____ Date _____

FOOD STORAGE

YES

NO

Designated area

Designated area

NO

Adequate space

Adequate space

NO

Meets temperature requirement

FOOD PREPARATION FACILITIES

YES

NO

Designated area

Designated area

NO

Adequate space

Adequate space

NO

UTENSILS/EQUIPMENT & STORAGE

YES

NO

Designated area

Potable water supply

NO

Adequate Space

Hot/cold water under pressure

NO

Mobile unit cleaning area

NO

Wastewater disposal area

NO

CLEANING/SANITIZING

Wash – Rinse & Sanitize Facilities

Observations/Comments:

