

North Central District Health Department

- Enfield - 31 North Main Street, Enfield, CT 06082 - (860) 745-0383 FAX 745-3188
- Vernon - 375 Hartford Turnpike, Room 120, Vernon, CT 06066 - (860) 872-1501 FAX 872-1531
- Windham - Town Hall, 979 Main Street, Willimantic, CT 06226 - (860) 465-3033 FAX 465-3032
- Stafford -Town Hall, 1 Main Street, Stafford Springs, CT 06076 - (860) 684-5609 FAX (860) 684-1768

APPLICATION FOR FOOD SERVICE CATERING LICENSE

Name of Establishment _____ Class _____

Establishment Address _____
(Street, City, State)

Phone No. _____ Fax No. _____ No. of Employees _____

e-mail address _____

Mailing Address (if different) _____

Business Days/Hours _____

Name of Owner _____ Home/Emergency No. _____

Address of Owner _____

Name of Manager _____ Home/Emergency No. _____

Home Address of Manager _____

Permitted Seating Capacity _____ State Licenses: Bakery ___ Café ___ Liquor ___ Other _____

Liquor Permittee _____

Water Supply Type: (Check all that apply) Public Water _____ Private Well* _____ SHD Jurisdiction _____
*Please enclose a copy of your current water report.

Sewage Disposal System Type: (Check all that apply) Public Sewer _____ Septic System* _____ Grease Trap* _____
*Please enclose a copy of your current pumper's reports.

For Information Purposes Only:

- I would prefer to file future renewals on-line
- I would prefer to file hard copy renewals

I attest that the above information is correct.

For Health Department Use Only

Amount Paid: _____

Restaurant ID No. _____

Applicant's Signature

Date: _____

Catering Food Service License Application

Location of licensed kitchen to be utilized for the catering operation:

Provide the name of the owner of the licensed kitchen, if not the same as listed on Page 1:

** Submit an agreement between the owner of the licensed kitchen and the caterer for use of the licensed facility.

List all other food service licenses held: _____

** Supply a copy of the menu or a listing of the food items to be served.

1. What is the source of the food to be served? _____

2. What is the source of the water supply to be utilized? _____

3. Describe the transport vehicle: _____

4. How will the food be protected during transport? _____

5. How will the cold food be maintained at 45°F or below during food production and transport?

6. How will hot food items be cooked for service? Will foods be pre-cooked and reheated? Describe these operations.

7. How and where will excess food and single service items be stored?

8a. How and where will utensils, china, glasses, pots, pans, etc., be cleaned?

8b. Will these items be owned or rented? _____

8c. Where will these items be stored? _____

9. Describe the hand wash facilities in the prep kitchen and at the site of the food service.

10. Describe the garbage disposal facilities. _____

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DECLARATION OF BASE OF OPERATION

This form must be submitted to the Health Department with your application for permit.

PLEASE PRINT CLEARLY

Date: _____

Business Name: _____

Owner/Operator Name: _____

Business Name of Base of Operation: _____

Address of Base of Operation: _____

Owner of Business Used as Base: _____

Owner's e-mail Address _____

Telephone Number of Base of Operation: _____

THE FOLLOWING PORTION TO BE FILLED OUT BY THE OWNER OF THE FOOD ESTABLISHMENT USED AS THE BASE OF OPERATION.

I, _____ attest that my licensed food establishment
Owner of food establishment used as base

known as _____ is available as the base of operations for
Name of food establishment

_____ owned by _____
Name of Catering Business Owner of Catering Business

Signature of Owner of Food Establishment

*****REMEMBER TO INCLUDE A COPY OF THE BASE OF OPERATION'S VALID FOOD PERMIT ISSUED BY THE LOCAL HEALTH DEPARTMENT*****

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Grease Trap @ Location of Wastewater Dump Sink Questionnaire

Name of Food Service Facility: _____

Address of Facility: _____

- This food service facility does not have a grease trap or grease interceptor.
- This food service facility has an interior passive style grease trap.

Location: _____

Size: _____

Frequency of cleaning: _____

Contracted disposal with: _____

- This food service facility has a large grease interceptor (exterior).

Location: _____

Size: _____

Frequency of Cleaning: _____

Contracted Cleaner: _____

***** Attach a copy of your most recent grease trap pumper's report with this form.**

- This food service facility has a mechanically cleaning BACT grease interceptor (i.e., Big Dipper, Highland Tank, etc.).

Please sign and fill in below:

Your Name: _____ Date: _____

This form MUST be completed by all Class 3 and Class 4 applicants - regardless of previous information supplied. Your application for a food service license will not be processed if returned blank or incomplete.

Establishment Name: _____

Estab. Address: _____
(Street) (City) (State)

PRIMARY Qualified Food Operator Information

Full Name: _____
(First) (Last) (Job Title)

Home Street Address: _____

(City) (State) (Zip) (Home Phone No.)

Name of Course Taken: _____ Date on Certificate: _____

A copy of your certificate of course completion must be submitted along with your license application - if not previously submitted.

REQUIRED: ALTERNATE Qualified Food Operator Information

The owner or manager of the food service establishment shall designate an alternate person to be in charge at all times when the qualified food operator cannot be present.

Full Name: _____
(First) (Last) (Job Title)

Home Street Address: _____

(City) (State) (Zip)

Home Tel. No.: _____ Course taken (if applicable) _____

REQUIRED: WRITTEN DOCUMENTATION OF TRAINING

Written documentation of a training program and training records of each employee are maintained and on file on site at this establishment.

YES _____ NO _____ Signed _____

Primary Qualified Food Operator

1. A copy of your certificate of compliance with the qualified food operator requirement must be maintained on file at the food service establishment at all times.
2. The Qualified Food Operator shall maintain written documentation of a training program, and training records of individual employees.
3. *The state Public Health Code now allows the Director of Health to close an establishment for non-compliance with Section 19-13-B42(u)(4) - QFO Requirements.*

STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH
DRINKING WATER SECTION
Food Service Establishment Water System Registration Form (Rev. 4/06)

Refer to instructions on reverse side for assistance in completing this registration form.

Are there changes to property and/or food service establishment ownership/contact information from this past year? Yes No

A. Food Service Establishment Information

New food establishment licensure Relicensure

Food Service Establishment Name: _____

Ownership information (food service establishment):

Name: _____

Mailing Address: _____

Phone Number: _____

Signature of food service establishment Owner: _____ Date: _____

B. Water System Information

What is the source of the water supply for this location?

Onsite Well

If "Customer of a Community PWS", do not complete Section B.

Customer of a Community Public Water System (PWS)

Provide name of Community PWS: _____

Water System/Property Name _____ PWSID*: CT _____

* If known / if applicable

Address of Water System: _____ Town: _____

List all businesses and/or facilities supplied by water system: _____

Do at least 25 persons (including employees, customers, parishioners, visitors, etc., but not necessarily the same persons) visit the facilities/businesses supplied by the water system daily at least 60 days out of the year? Yes No

Total number of same persons who regularly use the facilities / businesses (i.e. employees, students, but not residents) for at least 6 months a year: _____ Avg. # of Daily Customers: _____ # of Residents: _____

Does this water system also supply water to a (check applicable): hotel/motel municipal bldg gas station
 medical facility rest area park/recreation area campground place of worship Other: _____

Type and number of wells: Drilled Wells _____ Shallow Dug Wells _____ Other: _____

Installed water treatment equipment: Iron/manganese filter Ultraviolet light Water softener Aeration
 Granular Activated Carbon filter Acid Neutralizer Other/Unk: _____ Chemical feed: _____

Water System annual operating period (begin/end dates of operation): From: _____ To: _____
month/day month/day

Water system ownership information (i.e. property owner):

Name: _____

Mailing Address: _____

Phone Number: _____

Signature of Property Owner: _____ Date: _____

Information below to be completed by the Local Health Department

1. Date: _____
2. Water System Classification (check one): NINC TNC NP Undetermined CWS Customer
3. Reviewed by (print name, title and LHD): _____
4. Signature: _____

Mail a copy on the completed registration form to: _____ If CWS customer, do not forward
to C.T. DPH - DWS
C.T. Department of Public Health - Drinking Water Section - CRS Unit
410 Capitol Ave. MS/51WAV1 - P.O. Box 340808, Hartford, CT 06134-0808