



ISLAND COUNTY HEALTH DEPARTMENT
 P.O. BOX 5000 • Coupeville, WA 98239-5000
 (360) 679-7350 • 321-5111 • 629-4522 • 240-5564

2009 FOOD SERVICE ESTABLISHMENT PERMIT APPLICATION

ESTABLISHMENT NAME _____

ESTABLISHMENT BUSINESS ADDRESS _____

CITY _____ ST _____ ZIP _____

DAYS OF OPERATION: M T W Th F Sa Su TELEPHONE# _____

HOURS: _____ AM/PM to _____ AM/PM

INDICATE MONTHS OF OPERATION _____

MAILING ADDRESS (if different from above)

CITY _____ ST _____ ZIP _____

OWNER'S NAME _____

ESTABLISHMENT MANAGER'S NAME _____

NAME OF WATER SYSTEM SERVING ESTABLISHMENT:

WATER SERVICE METERED YES _____ NO _____

METHOD OF SEWAGE DISPOSAL:

Public Sewer System	YES _____	NO _____
Septic Tank/Drainfield	YES _____	NO _____
Community Drainfield	YES _____	NO _____

(If drainfield please fill out attached sheet and submit Asbuilt)

ESTABLISHMENT CATEGORY

___ Bakery (Baked Goods Only)

___ Bed and Breakfast (Full Meal)

___ Candy Kitchen/Confectioner

___ Caterer/Cottage Industry

___ Convenience Store
 (Groceries & Prepackaged Food Only)

 ___ With Food Service

___ Espresso Stand (non-hazardous foods)

___ Farmers Market

___ Food Establishment

 ___ No Seating

 ___ Number of Seats

 ___ With Cocktail Lounge

___ Grocery

 ___ 1-2 checkout stands

 ___ 3-4 checkout stands

 ___ over 4 checkout stands

 ___ with meat and/or fish

 ___ with delicatessen

 ___ with bakery

___ Institutional Kitchen

 ___ Full Kitchen

 ___ Satellite Kitchen

___ Non-Profit Permanent (Must Provide
 Proof of Tax Exempt Status)

___ Retail Commercial Fishing Vessel

___ Taverns without food

The permit fee for each food establishment shall be adopted by the Island County Board of Health. All permits issued hereunder shall terminate on the 31st day of December in the year of issue. Please remit fee payable to the Island County Health Department.

***** For Payment Later Than 30 Days There Will Be An Additional Fee Charged At 1/2 Of The Base Fee *****

NOTE: PERMITS ARE NOT TRANSFERABLE IN EITHER PERSON OR PLACE. BE SURE THAT NAME AND ADDRESS IS THAT OF THE LEGAL OWNER OF BUSINESS AND IS CORRECT.

SIGNATURES OF LEGAL OWNER(S) OF ESTABLISHMENT

DATE: _____

FOR HEALTH DEPARTMENT USE ONLY BELOW THIS LINE

RECEIPT NO. _____

AMOUNT RECEIVED: _____

DATE APPROVED: _____