Application for a License to Operate
Food Service Establishment - Class IV

Town of Greenwich
Department of Health
Division of Environmental Services
101 Field Point Road
Greenwich, CT 06830
(203) 622 – 7838
www.greenwichct.org

Name of Facility: __________________________________________________________________________
Address: _________________________________________________________________________________
Telephone: _______________  Fax Number: _______________  Parcel Tax ID Number: _____________

Name of Owner: ___________________________________________________________________________
Address: __________________________________ City: __________________ State: _____  Zip: ______
Telephone: _______________  email address: __________________________

☐ If checked, all correspondence will be sent to the Owner Address not the Facility Address

Person Responsible (If Not Owner): ___________________________________________________________
Home Address: ________________________________ City: __________________ State: _____  Zip: ______
Home Telephone: _______________  email address: __________________________

Name of Qualified Food Operator(s)*: __________________________________________________________
Position(s) Held: ________________________________ Number of Hours Worked Weekly: ______________

Name of Designated Alternate(s): ____________________________________________________________
Position(s) Held: ________________________________ Number of Hours Worked Weekly: ______________

*ATTACH CERTIFICATE(S) OF ALL QUALIFIED PERSONNEL

Type of Facility (Check One) Nature of Application (Check One)
_____ Food Store   ____ New Facility
_____ Food Service Establishment   ____ Change of Ownership
_____ Seasonal Restaurant (6 Months or Less)   ____ Remodeling or Conversion
_____ Temporary Establishment (14 Days or Less)   ____ License Renewal
_____ School   Alcohol Provisions (Check One)
_____ Club or Hotel   _____ Liquor Served
_____ Caterer   _____ Beer and/or Wine Only

Water Supply (Check One)  Sewage Disposal (Check One) Smoking Provisions (Check One)
_____ Public Supply   ____ Town Sewer   ____ Smoke Free
_____ Private Well   ____ Septic System   ____ Smoking Area Provided

Consumption of Food on Premises (Includes Stand-up Counters / Bar Service):  YES / NO
Total Seating Capacity: __________  Number of Bathrooms Available to the Public: ______

Over →
Building Information

Owner of Building: ___________________________________________________________
Address: ________________________________City: ___________________State: _____Zip: _______
Telephone: _________________  email address: __________________________

Hours of Operation –

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Public Health Alerts –

The Department frequently receives information from a variety of sources – including the Connecticut Departments of Public Health and Consumer Protection as well as the Food and Drug Administration – that may pertain to food products you may be serving. It is critical that we release this information to as many people as quickly as possible, in order to reduce the possibility of someone falling ill due to contaminated products. So that we can ensure that the information gets to the appropriate person at your food service establishment in a timely fashion, please provide an email address (preferred) or a fax number that is checked on a daily basis by someone with knowledge of the food products your establishment sells.

Email:  ________________________________    or   Fax:  _____________________________

I, the undersigned, hereby apply for a license to operate a Food Service Establishment in the Town of Greenwich. If granted, I agree to give permission to the Greenwich Department of Health to inspect as often as deemed necessary, and I will abide by all provisions of State and Local regulations regarding eating and drinking places.

Name of Applicant: ___________________________________________ Date: _____________________

Signature of Applicant: ________________________________________

*Please provide all information requested. Incomplete applications will be returned.