

CONTRA COSTA ENVIRONMENTAL HEALTH DIVISION

2120 DIAMOND BOULEVARD, SUITE 100 CONCORD, CA 94520 (925) 608-5500 (925) 608-5502 FAX www.cchealth.org/eh/



PERMIT TO OPERATE APPLICATION FOOD FACILITY AND PUBLIC POOL

	Restaurant# seats Retail Food Market# sq. ft. Charitable Feeding Incidental Retail Food Market# sq. ft. Bakery# sq. ft. Food Demonstrator Cocktail Lounge/Bar	0000000	Commissary – Vehi Snack Bar Production Kitchen Production Kitchen Farm Stand School Cafeteria School Satellite	(Restaurant) (Non-Restauran	t)	Recrea Spray (Skilled Host Fa	nal Pool / Spa # tional Water Park Grounds Nursing Facility			
(Fac	Vending Machine CTION 2: Contact Information cility Address and Permit Holder Address must be did f ONLY Change of Facility Name (DBA), Change of	Addres	ss or Co-Owner Add /	Drop Name - Co						
A.	Facility Name and Address: Is postal mail delivered at the facility? Yes (If yes, please skip Part B) No (If no, please complete Part I NEW FACILITY (BUSINESS) NAME / DBA: ADDRESS:									
	CITY/STATE/ZIP CODE:			PHONE #:			FAX #:			
	PREVIOUS FACILITY NAME / DBA:									
В.	Facility (Mailing) Address: ADDRESS:									
	CITY/STATE/ZIP CODE:			PHONE #:			FAX #:			
C.	Permit Holder Name and Address: (Permit I	Holder	Address and Facili	ty Address mus	Sole I	Proprietor	addresses) Co-Owners INC tification or documentation			
	ADDRESS:									
	CITY/STATE/ZIP CODE:			PHONE #:			FAX #:			
D.	Accounts Receivable (Invoice) Address: IN CARE OF (Billing Office or Person in Charge):									
	ADDRESS:									
	CITY/STATE/ZIP CODE:			PHONE #:			FAX #:			
E .	Email Address: For Official Inspection Rep email addresses. (REQUIRED)	orts.	Email address that	is provided nee	eds to b	e able t	o accept email fro	om external		

		n Co-Owner)	☐Articles of I	ncorporation/Or	rganization 🖵	Documents from	escrow com	panies		
□Charitable □Blind: prov	provide DD214 F or Tax Support	lonorable disc ed Institution ned by a licen	charge papers s: provide IRS sed physician of	letter of confirm or by the State		ritable 501c3 orga itional Rehabilitati		on is blind (having not more	
SECTION 5: Per Facility Mai	rmit Mailing Ad ling Address (B)	ddress	□F	Permit Holder M	ailing Address	(C) \ A	ccounts Rec	eivable Ado	dress (D)	
	achments with Kitchen/Approve y Permit Excepti	d Facility Agre	ement Comple	ted (for Catere	,	uare feet)				
☐Change of I	odd / Drop Name Facility (DBA) Na Address:	: me:				ay Apply)				
· ·		Mailing		□Permittee		□Accounts F	Receivable			
SECTION 8: Ter	ms/Signature									
Envi men The char appr The regu outs	The undersigned hereby certifies all of the information provided on this application is true and accurate and agrees to notify Environmental Health Services of any changes that occur including the type of business activity, name, business location, menu, equipment, billing address, ownership and/or closure. The undersigned further agrees and understands that any structural alterations, including, but not limited to, equipment changes or additions requires the submittal of plans and appropriate fee to Environmental Health Services for review and approval. The undersigned hereby applies for a Permit to Operate and agrees to operate in accordance with all applicable state and local regulations, laws, and such inspection procedures needed to ensure compliance. Payment of the required permit fee and outstanding inspection fee balance, if any, to secure a valid permit is required before commencing or continuing operations. Failure to do so may result in a misdemeanor citation, infractions, permit suspension/revocation proceedings, and/or closure.									
	PERMITS ARE NOT TRANSFERABLE									
man	Signature(s) must be Permit Holder/Owner, Partner or Corporate Officer (Corporation and Limited Liability Companies). A manually signed copy of this application delivered by facsimile, email, or other electronic transmission shall be deemed to have the same legal effect as delivery of an original signed copy of this application.									
Sign	Signature of Applicant: Date									
Аррі	icant Name: (Ple	ease print)								
FA#:	PR#:		P/E#:	OFFICE	USE ON EHS:	SUPERVISOR:	RECEIVE	D BY:	DATE RECEIVED:	
AD#.		INT DUE (Ain Fac	AMOUNT DUT	amait (Day and a M	4-4).		AMOUNT 5:	D	
AR#:	\$ \$	UNT DUE for Inspec	uon rees:	\$	ermit (Prorated, If nee	ded): TOTAL Amou	ant Due:	AMOUNT PAI	U	
SR#	•	CREDIT CARD:	CASH		CHECK #:	•	RECEIPT #:			

FOR PROGRAM CLERK USE ONLY

INFORMATION MATCHES ENVISION

PROGRAM CLERK INITIALS: