ERIE COUNTY DEPARTMENT OF HEALTH
FOODSERVICE FACILITY PERMIT APPLICATION
FOR INFORMATION, CALL (716) 961-6800
This application is not a permit.
Operation of a regulated facility without a valid permit is a violation of the Sanitary Code.
This application must be submitted at least 21 days before the start of operation or prior to the expiration date of the existing permit
PLEASE PRINT OR TYPE – ILLEGIBLE OR INCOMPLETE APPLICATIONS WILL DELAY PROCESSING

☐ *Restaurant 0-50 Seats* ☐ *Restaurant over 50 seats* ☐ *+Frozen Dessert*
☐ *Caterer* ☐ *Mobile Food Truck* ☐ *Push Cart*
☐ *Food Commissary Prep & Storage* ☐ *Food Commissary Storage Only*
☐ *Ownership change of existing facility* ☐ *Name change only of existing facility*

FACILITY INFORMATION

Facility Name (as it will appear on permit) ____
Facility Street Address ____
Facility City, Zip Code ____________________________ Facility Phone ____________________

OWNER / OPERATOR INFORMATION

Corporation Name ____
Owner/Operator Name____
Address ____
City, State, Zip ____
Phone ______________________________ email ____________________________________

MAILING ADDRESS

☐ Billing / Correspondence to be sent to facility address as above
☐ Billing / Correspondence to be sent to Owner/Operator address as above
☐ Send all correspondence to alternate address: Name ___________________________
Address ____
City, State, Zip ____
Email contact ____

Workers Compensation and Disability Insurance Information

Indicate below the form provided as proof

Workers Compensation Insurance

☐Form C-105.2 ☐ Form U-26.3 ☐ Form SI-12 ☐ Form GSI-105.2

NYS Disability Insurance

☐ Form DB-120.1 ☐ Form DB-155

Certification of Attestation of Exemption from NYS Workers Compensation and/or Disability Benefits Coverage

☐ Form CE-200

For CE-200, you can apply at www.businessexpress.ny.gov .You will be asked to create a NY.gov account if you do not already have a login.

Mobile Food Trucks & Pushcarts

A letter from the owner of the permitted facility granting permission to utilize their kitchen must be submitted along with this application

Name of Commissary ____
Commissary Address ____
Commissary City, Zip Code ____________________ Commissary Phone ____________
Contact person at commissary ______________________________________

License Plate # / VIN # (if applicable) _________________________________

WATER / SEWAGE FACILITES AT ESTABLISHMENT

☐ Public Water ☐ Private Water (Well) ☐ Public Sewer ☐ Private On-Site Waste-Water Treatment System

If private water/sewage please specify operator/responsible party ____________________________

CORPORATION / PARTNERSHIP / LLC / ADDITIONAL OFFICERS

List all officers/partners:

Name	Title	Address	Telephone	email

DAYS / HOURS OF OPERATION

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Opening Time							
Closing Time							

Seasonal facilities please specify months of operation:

☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sep ☐ Oct ☐ Nov ☐ Dec

If this application is approved, the undersigned applicant hereby agrees to operate the facility described in complete compliance to the New York State Sanitary Code and any other rules, codes, regulation applicable to its operation. Applicant also acknowledges that workers compensation and disability benefits insurance are in force as required.

Date ______________ Signature of Operator__________________________ Title____________
Print Name ______________________________

PLEASE MAKE CHECK PAYABLE TO "COMMISSIONER OF FINANCE"

Send application and fee to: Erie County Dept. of Health
503 Kensington Ave.
Buffalo, NY 14214