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Director of Health

City of Middletown

Department of Health
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Food Establishment License Application

Establishment

Name:_________________________________

Address:________________________________

Phone:_________________________________

State:_________ Zip:________________

Email:_________________________________

Owner/Agent/Operator

Name:____

Agent/Operator:_______________________________

Address:_____________________________________

City:_______________Phone:___________________

State:_________ Zip:______________________

Email:_______________________________________

Certified Food Protection Manager 1.______________________________

Alternate Person in Charge 1. _____________________________ 2. _______________________________

Provide a copy of valid certificate

Signature: Owner/Agent: ____ **Date:**_________________

OFFICE USE ONLY:

Establishment Type: (Circle all that apply)

Class: 1 2 3 4 **District:** 1 2 3 **Detailed Floor Plan Received:** Y N

License Month: J F M A M J J A S O N D

Plan Review Fee? Y N **Date Plan Review Fee Paid** _____/_____/_______

License Fee $__________ **Date License Fee Paid:** ______/______/________ **Cash Check #**__________

Authorized Health Department Representative: ______________________________ **Date:** ___________