



APPLICATION FOR FOOD SERVICE ESTABLISHMENT PERMIT
 (Please type or print)

1) Establishment Name: _____
 Street Address _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ Fax Number: _____
 Email Address: _____

2) Owner Name: _____
 Owner Address: _____
 City: _____ State: _____ Zip Code: _____
 Phone Number: _____ Fax Number: _____

3) Signature of Applicant: _____ Date: _____
 Print Name of Applicant: _____

4) Make Checks Payable to: *Polk County Health Center*

Establishment Fees: Pre-Opening Inspection-----\$100.00
 Low Priority-----\$100.00
 Medium Priority-----\$150.00
 High Priority-----\$200.00

For Polk County Health Center Use Only

Establishment # _____
 Issue Date _____ Expiration Date _____
 Notes: _____