



WHATCOM COUNTY HEALTH DEPARTMENT

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Bellingham, WA 98225
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ANNUAL FOOD SERVICE ESTABLISHMENT PERMIT APPLICATION

[] New Facility Application Date opening _____ FEE _____
[] Change of Ownership Date of change _____ Prior Facility Name _____
[] Information Update Only

NAME OF ESTABLISHMENT _____

ADDRESS OF ESTABLISHMENT _____

CITY _____ STATE _____ ZIP _____ PHONE _____

NAME & ADDRESS TO WHICH INSPECTION NOTICES AND CORRESPONDENCE SHOULD BE MAILED:

MANAGER NAME _____

OWNERS NAME _____ PHONE _____

TYPE OF OWNERSHIP: Individual [] Corporation [] Partnership [] LLC []

If partnership, corporation or LLC, Fill in name, address and phone of partners or corporate officers:

NAME ADDRESS PHONE
1. _____
2. _____

DAYS & HOURS OPEN FOR BUSINESS _____ SEATING CAPACITY _____

ADDITIONAL SERVICES: Full Service Bar [] Espresso [] Deli [] Other: _____

IF APPLICATION IS FOR A MOBILE UNIT, NAME & ADDRESS OF COMMISSARY:

NAME OF WATER SYSTEM _____ METHOD OF SEWAGE DISPOSAL _____

I understand that in accordance with WAC 246-215-230, the person in charge of any food service establishment shall permit the health officer, after proper identification, to enter at any time, for the purpose of making inspections or investigations to determine compliance with these regulations. The health officer shall be permitted to examine the records of the establishment to obtain information pertaining to food and supplies purchased, received, or used and to any person employed which is pertinent to an illness investigation or other matters which may affect health or the enforcement of these regulations.

DATE _____ SIGNATURE OF APPLICANT _____

OFFICE USE ONLY

Inspected By _____ Program/Element Code _____ Additional Service _____
Date Approved _____ Next Inspection _____ Assigned to _____
Permit Expiration _____ Category _____ Bill Additional Pre-Open: Y or N
Facility # _____ Program # _____ Account # _____
Received By _____ Date _____ Amount Paid _____ Check # _____