NEW FOOD SERVICE ESTABLISHMENT
PERMIT APPLICATION

Environmental Health Services
CHEMUNG COUNTY HEALTH DEPARTMENT
103 Washington Street, Post Office Box 588
Elmira, New York 14902

Phone: (607) 737-2019
Fax: (607) 737-2059
www.ChemungCountyNY.gov
email: EHS@ChemungCountyNY.gov

For Office Use Only	
	Prorated Fee amount: _____
	(minus) Site Eval fee paid: _____
	Balance Due: _____
	Date Paid: _____ Recpt #: _____
	Approved by: _____
	Effective: _____ **Expir:** _____

It is a violation of the NYS Sanitary Code and the Chemung County Sanitary Code to operate a Food Service Establishment without a valid permit. **Please type or print** the required information and *return the completed application and fees to the above address* ***at least 21*** *days before the first day of operation.* Failure to do so may delay issuance of your permit to operate. ***Make checks payable to: Chemung County Health Department***

ESTABLISHMENT TYPE *(Check all that apply):*

☐ **Restaurant** - Full Service ☐ **Restaurant** - Fast Food/Light Meals ☐ **Catering** - Off Premise
☐ **Mobile Unit/Pushcart** ☐ **Tavern** – Beverages & snacks only ☐ **School**
☐ **Church/Fire Dept** ☐ **Vending machines** ☐ **Other:** _____

For Office Use Only:
FS Estab. #: _____
Op ID #: _____
Date C of O issued: _____
Risk Level Assigned: ☐ **High** ☐ **Med** ☐ **Low**

SECTION A - FACILITY INFORMATION (Entire section must be completed by all applicants)

Facility Name: _____ **Phone:** _____

Facility Address:_____

City, State, Zip: _____

Please indicate where you would like permits & renewal paperwork sent -
Mailing Address:_____

City, State, Zip: _____

In Operation *(check one)*: ☐ **Year-round** ☐ **Seasonal** *(no more than 6 months)* - Opening Date: _____ Closing Date: _____

Days/Hours of Operation: *(Please list all days and hours that you are open for business):*

Seating Capacity: _____

Water supply *(check one)*: ☐ Public ☐ Private ***(If Private** - Type of Water Disinfection:* ☐ *Chlorinated* ☐ *UV Radiation* ☐ *None)*

Sewage System *(check one)*: ☐ Public ☐ Private

Is any food prepared at another location? ☐ No ☐ Yes, (If Yes, state location: _____)

SECTION B – OWNER/OPERATOR INFORMATION

Legal Operator or Operating Corporation: _____ **Email Address** (required): _____

Operator Address: _____ City, State, Zip: _____

Phone: _____ Cell Phone: _____ Fax #: _____

>>> Is Owner information the same as the Operator information listed above? ☐ Yes ☐ No >> If No, please complete the section below:

Owner Name: _____ **Email Address:** _____

Owner Address: _____ City, State, Zip: _____

Phone: _____ Cell Phone: _____ Fax #: _____

Manager's Name: _____ Phone: _____ Cell Phone: _____

>>> Is owner/operator a Corporation or Organization? ☐ Yes ☐ No **(If YES, Please fill out Section G on back).**

SECTION C – WORKER'S COMPENSATION & DISABILITY INSURANCE INFORMATION

This is to certify, under the penalties of perjury, that the above described operation either has Worker's Compensation and Disability Benefits coverage when required by law **OR** has completed CE-200 stating that such coverage is not required (see attached instructions on how to complete this form).

Worker's Compensation Insurance (Attach proof of Insurance form to application). Check which form is provided as proof:

☐ Form C-105.2 ☐ Form U-26.3 ☐ Form SI-12 ☐ Form GSI-105.2 *(note:* ***Acord*** *Forms cannot be accepted as proof)*

Disability Insurance (Attach proof of Insurance form to application) Check which form is provided as proof:

☐ Form DB-120.1 ☐ Form DB-155 *(note:* ***Acord*** *Forms cannot be accepted as proof)*

OR -- > ☐ **Form CE-200** submitted to this Department on: _____ *(This exemption form need only be filled out if you do not have insurance listed above)*

Note: You must ***attach*** *a copy of your completed form CE-200 to this application, please be sure to* ***sign*** *the bottom of this form.*

SECTION D – Complete for SEASONAL FOOD SERVICE* Establishments only

**** To qualify as Seasonal, your establishment must be open for business no more than 6 consecutive months per year.***

Expected Opening Date: _____ **Expected Closing Date:** _____

Food to be served: _____

_____

A PRESEASONAL INSPECTION IS REQUIRED - PLEASE CALL 737-2019 FOR AN APPOINTMENT

SECTION E - COMPLETE FOR MOBILE FOOD SERVICE UNITS OR PUSHCARTS ONLY

Type of vehicle: ☐ Motorized (License plate #: _____) ☐ Pushcart ☐ Other:_____

Commissary address* *(Location where food is made and/or stored):* _____

Food to be served: _____

A PRESEASONAL INSPECTION IS REQUIRED - PLEASE CALL 737-2019 FOR AN APPOINTMENT

SECTION F - COMPLETE FOR VENDING (FOOD AND BEVERAGE MACHINES) or CATERING

Commissary address* *(Location where food is made and/or stored):* _____

>>> Please attach a list of all vending machine locations and food dispensed at each location.

***Note:** **If commissary is located outside of Chemung Co.** you must attach a copy of your most recent inspection report by the local Health Department along with a copy of a valid Health Permit for the facility.

SECTION G - CORPORATE OFFICERS OR ORGANIZATION LEADERS

List all corporate officers or organization leaders involved in the operation of the facility. Include vice president(s), secretary, treasurer, etc. Attach additional sheets as necessary.

Name:	Title:	Home Address:	Home Phone:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

SECTION H – BUILDING OWNER INFORMATION

Regarding the building in which your Food Service Establishment will operate (mark one):

☐ I own the building

☐ I rent/lease the building from _____ Contact Phone: _____

SECTION I - SIGNATURE - - - ENTIRE SECTION MUST BE COMPLETED BY ALL APPLICANTS - - -

FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW.
Failure to sign this form will delay issuance of your permit to operate. **APPLICATION FEES ARE NON-REFUNDABLE.**

I certify that the information provided on this application is true.

SIGNATURE OF OPERATOR: _____ **Date:** _____

Print Name: _____ Title: _____

INSTRUCTIONS FOR FILLING OUT ATTACHED APPLICATION

Please fill in the required information on the attached application. Please note the following:

- ***APPLICATION FEES ARE NON-REFUNDABLE – Make checks payable to Chemung County Health Dept.***
- ***Please provide us with your e-mail address.*** ***Inspection reports will now be electronic and have to be emailed to the facility operator.***
- ***WORKERS' COMPENSATION AND DISABILITY INSURANCE***
  As a government agency, we are prohibited from issuing permits until you submit either proof of insurance or a CE-200 Exemption form. See below for details.
- ***SIGNATURE*** *- All applications must be signed (on back).*

Workers' Compensation and Disability Insurance Requirements for Permitted Facilities

The following forms must accompany the application to document compliance with the Worker's Compensation Law. Permits will not be issued without this paperwork.

These forms can be sent directly to our office by your insurance agent via email to EHS@chemungcountyny.gov, fax (607) 737-2059, or they can be mailed to our office along with your application. For security reasons we ask that if these documents are emailed to us the sender include the name of the facility in the subject line.

➔ When Worker's Comp and/or Disability coverage IS provided.

Proof of Workers' Compensation Insurance:

One of these:

- **Form C-105.2** – Certificate of Worker's Compensation Insurance (**Contact your Insurance carrier**; they will have to generate this form). **Note:** Form **C-105** is not acceptable proof, must be form **C-105.2**

OR

- **Form U-26.3** – Certificate of Workers' Compensation Insurance (Issued by the **State Insurance Fund**, you will have to contact them).

OR

- **Form SI-12** – Certificate of Workers' Comp Self-Insurance (usually only applies to major corporations or government agencies).

OR

- **GSI – 105.2** – Certificate of Participation in Workers' Compensation Group Self-Insurance (usually only applies to major corporations or government agencies).

AND

Proof of Disability Benefits Insurance:

One of these:

- **DB-120.1** - Certificate of Disability Benefits (**Contact your Insurance carrier**; they will have to generate this form). **Note:** Form **DB-120** is not acceptable proof, must be form **DB-120.1**

OR

- **Form DB-155** – Certificate of Disability Benefits Self-Insurance Insurance (usually only applies to major corporations or government agencies).

Important: Acord Forms are not acceptable as proof of insurance coverage.

➔ When Worker's Comp and/or Disability coverage IS NOT provided.

Form CE-200 – Certificate of Attestation of **Exemption** from NYS Workers' Compensation and/or Disability Benefits Coverage is required.

You can obtain form CE-200 from the following:

On-line – Through Worker's Comp Board website at:

https://www.businessexpress.ny.gov/app/loginregister

- Or you can email us at EHS@chemungcountyny.gov or call our office at **607-737-2019** to request that we email you the link to the Worker's Comp Board Website along with instructions on how to complete the form online.

Submit the completed and signed CE-200 to our office along with your application.

The CE-200 is a one page document that should look like this:

