

# TEMPORARY

Food Service Permit Application – **2017**

Lake County Health Department

**APPLICATIONS MUST BE RECEIVED A MINIMUM OF 10 DAYS PRIOR TO THE EVENT**

Food Service Name: \_\_\_\_\_

Business Owner: \_\_\_\_\_ Phone No.: \_\_\_\_\_

Mailing (Street): \_\_\_\_\_

Mailing (City / Town): \_\_\_\_\_ (State): \_\_\_\_\_ (Zip): \_\_\_\_\_

Tax Exempt No.: \_\_\_\_\_

LIST THE EVENTS FOR WHICH YOU ARE REQUESTING A PERMIT(S)  
**(PERMIT FEE IS \$10.00 A DAY UP TO \$30.00 PER EVENT PER STAND)**

**Please Note: Out of State/County vendors must provide last inspection from commissary/kitchen where food is prepared and stored and complete contact information**

Name of Event

Location

Event Date/Time

1. \_\_\_\_\_

**LIST ONLY ONE EVENT PER APPLICATION**

LIST KINDS OF FOODS THAT WILL BE PREPARED AND SERVED

1. \_\_\_\_\_ 5. \_\_\_\_\_ 8. \_\_\_\_\_

2. \_\_\_\_\_ 6. \_\_\_\_\_ 9. \_\_\_\_\_

3. \_\_\_\_\_ 7. \_\_\_\_\_ 10. \_\_\_\_\_

Is food prepared & stored on-site? (Yes / No) If no, name of commissary & address: \_\_\_\_\_

**ON THE REVERSE SIDE OF THIS FORM DRAW THE EQUIPMENT LAY-OUT PLAN FOR THIS TEMPORARY STAND**

Applicant's Signature: \_\_\_\_\_

PRINT Applicant's Name: \_\_\_\_\_

**PERMIT MUST BE POSTED VISIBLY IN THE STAND**

(Do not write in this space)

(FOR HEALTH DEPARTMENT USE ONLY)

Fee Due: \_\_\_\_\_ Fee Paid: \_\_\_\_\_ Date Paid: \_\_\_\_\_ Permit No.: \_\_\_\_\_

Mail fee and completed application to: **LAKE COUNTY HEALTH DEPARTMENT**  
**2900 W. 93<sup>RD</sup> AVENUE**  
**CROWN POINT, IN 46307**

REVIEWED BY (SANITARIAN): \_\_\_\_\_

**NOTE: CASH/BUSINESS CHECK/MONEY ORDER ONLY (NO PERSONAL CHECKS)**