



CHANGE OF OWNERSHIP REQUEST FOOD SERVICE ESTABLISHMENT

Central Nevada Health District
Churchill County Administration
485 West B Street Suite 101, Fallon, NV 89406

Permits are non-transferrable from one owner to another.
Incomplete forms may be returned or rejected

FOOD SERVICE NAME AND LOCATION

NEW FACILITY NAME: _____

PREVIOUS FACILITY NAME: _____

NEW OWNER NAME: _____

FACILITY STREET: _____

CITY: _____ ZIP: _____

PERMIT NUMBER: PR _____

NEW OWNER MAILING INFORMATION *REQUIRED*

OWNER NAME*: _____

BUSINESS NAME: _____

ADDRESS*: _____

CITY*: _____ STATE*: _____ ZIP*: _____

EMAIL: _____

DAYTIME PHONE*: _____ - _____ - _____

| | | |
|----------------------|------------------------------|-----------------------------|
| Has there been a: | | |
| Change in Menu? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change of Seating? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change of Equipment? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Change in Layout? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

| | |
|--|--|
| When was the previous business closed? | |
| <input type="checkbox"/> Less than 90 Days | |
| <input type="checkbox"/> 90 Days to 1 Year | |
| <input type="checkbox"/> 1 Year + | |
| <input type="checkbox"/> Unknown | |

Notice: By submitting this form, you attest to the accuracy of the information and that you will comply with the food code.

SIGNATURE: _____

DATE: _____

New owner may begin operation, once payment has been received PROVIDED THAT no changes have been made in the facility (i.e. menu change, equipment, seating, layout etc.) and it has been less than 90 days since previous operations ended.

If a facility has been closed more than 90 days OR a facility's menu, seating, equipment, or layout has changed; you must obtain approval from a health inspector prior to operating.

| | | | |
|---|-----------------------|----------------------------|--------------|
| Complete if applicable: | | PAYMENT INFORMATION | |
| Date opened/ Expected date _____ | Permit Fee | \$ | _____ |
| Seasonal operation: Date of opening _____ Date of closing _____ | Late Fee | \$ | _____ |
| Seating capacity (if seating is provided) _____ | Field Plan Review Fee | \$ | _____ |
| | Seasonal Fee | \$ | _____ |
| | Total Due | \$ | _____ |
| Cash and Check Only | | | |

OFFICE USE ONLY

PR _____ FA _____ PE _____ PLAN REVIEW SR _____ VARIANCE SR _____

CHECK NUMBER _____ CREDIT CARD APPROVAL _____ DATE FACILITY OPENED ____/____/____

INSPECTOR NAME (print) _____ SIGNATURE _____ DATE ____/____/____

APPEND? REVERSED PREVIOUS OWNER CHARGE? PREVIOUS OWNER OUTSTANDING BALANCE? PRIOR OWNER LAST INVOICE # _____