Central Nevada Health District
485 West B Street Suite 101 Fallon, NV 89406
Ph: (775) 867-8181
https://www.centralnevadahd.org/
info@centralnevadahd.org

APPLICATION FOR PERMIT TO OPERATE A FOOD FACILITY

Name of Establishment _____ Phone _____

Street Address _____

Assessor's Parcel Number _____-_____- _____email_____

☐ City of Fallon ☐ Lovelock ☐ Hawthorne ☐ Eureka ☐ Unincorporated area

☐ Mailing Address (if different than street address) _____

FOOD SAFETY CERTIFICATION INFORMATION

Testing Company/Test Type _____ Certificate Issue Date _____

Name (as printed on certificate) _____ Certificate # (if available) _____

As the owner of this establishment, I certify that should a permit be granted, I shall observe the statutes and regulations pertaining to the operation of this establishment as may be promulgated. I also agree that the representatives of Central Nevada Health District may make inspections and examine records during the hours when the business is open to the public. By signing this application, I agree to defend, indemnify, and hold the county harmless from any claim, action, or proceeding brought to attack, set aside, void or annul the county's approval of this application.

_____ _____

(Signature) (Date)

_____Please check here if there has been **no change** in this operation, menu, equipment or design since the previous application, **(including ownership)**. If no change, do not to complete the remainder of this form. If change has occurred, please describe here and complete the remainder of this form. _____

_____

Food Facility Owner _____ Phone _____

Address of owner _____

Email_____

Manager (if not owner)_____ Phone_____

Owner of building _____

Address of building owner _____

Establishment Type_____ Square Footage_____

Utensils Used: Multi-use_____ Single Service (disposable) _____

Has this building been used as a food establishment before_____ If yes, name of most recent business_____

Water Supply: Public System_ _ Name_____

Private System _ _

Water Source: Well_____ Spring_ _ Creek_ _ Other (describe)_____Number of Service Connections_____

Do you serve an average daily number of 25 people 60 days per year? Yes_ _ No_ _

Sewage Disposal: Public Sewer_____ Onsite septic tank and leach field_ _

Date Received _____

Amount Due _____

Please ensure all information is current so that our database may be updated

Renewal _____

New _____ Date _____

Owner change_____ Date _____

Approved by_____ Date _____