

Parke County Health Department

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parkecounty-in.gov

2019 Annual Food Permit Application

(Please Print Clearly)

This application is for Operating Permits for Food Service Establishment, Markets, and Caterers. **YOU MUST FILL OUT ALL INFORMATION OR THIS APPLICATION WILL NOT BE PROCESSED. A LATE FEE OF \$50.00 WILL BE ADDED IF POSTMARKED AFTER DECEMBER 31ST.** We accept Cash, Checks, Money Orders, Discover, Visa, or MasterCard (credit/debit card processing fees apply). If paying via card please complete page 4 of this application and turn in with the completed application. **IF SENT VIA MAIL, A PRE-STAMPED AND ADDRESSED ENVELOPE MUST BE SENT WITH THE APPLICATION.** If an envelope is not included with application, the permit will available at the Health Department during regular business hours.

Establishment Name: _____

Establishment Address: _____

Establishment Telephone #: _____

Owner's Name: _____

Owner's Mailing Address: _____

Owner's E-Mail Address: _____

Owner's Telephone # _____ for Recall Notices/Emergency ONLY

Owner's Fax#: _____ for Recall Notices/Emergency ONLY

Operator: _____ Directly Responsible for Establishment i.e. Manager

Operator's Mailing Address: _____

District Manager (if applicable): _____

District Manager Mailing Address: _____

District Manager Telephone #: _____

Certified Food Handler: _____

Food Handler Certificate #: _____

(If applicable, you must have a certified food Handler on Staff. **This information *must* also be available at the establishment.**)

IMPORTANT REMINDER

All changes of personnel must be reported to the Parke County Health Department immediately.

Hours of Operation

Sunday _____

Monday _____

Tuesday _____

Wednesday _____

Thursday _____

Friday _____

Saturday _____

I, _____, attest to the accuracy of the information provided in this application. I allow the Parke County Health Department access to the establishment of application and all pertinent records as specified in 410 IAC 7-15.5 and IAC 7-24 in compliance with the Parke County Food Protection Ordinance – 4.

Date of Application: _____ Amount Enclosed: _____

Signature of Owner or Manager: _____

Parke County Health Department

Credit/Debit Card Payment Authorization Form

The completion and signing of this form authorizes the Parke County Health Department use of the credit/debit card information listed below. The Parke County Health Department also has permission to debit the account for any fees due to applicant.

Please complete fully

I, _____ authorize the Parke County Health Department to charge my credit/debit card account in an amount due for licenses, permits, or vital record searches and/or certificates on or after _____.

Signature _____

I authorize the above named to charge the credit/debit card indicated in this authorization form according to the terms outlined above. This authorization is limited to one use. I certify that I am an authorized user of the aforementioned card. I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name: _____

Billing Address: _____

Phone: _____

City, State, Zip: _____

Email: _____

Office Use Only

Authorization # _____ Initials: _____ Date: _____

Please Fill Out Card Information

Account Type (Circle One): Visa MasterCard Discover

Account Number: _____ Expiration Date: _____

Security Code (3 Digit): _____