



# Northeast District Department of Health

69 South Main Street, Unit 4

Brooklyn, CT 06234

Phone - (860) 774-7350 / Fax - (860) 774-1308

[www.nddh.org](http://www.nddh.org)

## Temporary Food License Application

**NOTE: PRIOR TO ANY PERMIT BEING ISSUED, A CURRENT WATER TEST (WITHIN 1 YEAR) MUST BE ON FILE IN THIS OFFICE.**

### **I. Event**

Name of Organization Applying for Permit: \_\_\_\_\_

Title of Event: \_\_\_\_\_

Location of Event: \_\_\_\_\_

Street Address: \_\_\_\_\_ Town: \_\_\_\_\_

Type of Facility, i.e. Church, Food Booth, Food Cart, etc. \_\_\_\_\_

Start Date: \_\_\_\_\_ End Date: \_\_\_\_\_ Operation Times: \_\_\_\_\_

Vendor name: \_\_\_\_\_

Is above organization a non-profit? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, tax exempt # \_\_\_\_\_

### **II. Contact Person (applicant or manager of event):**

Name: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ ST: \_\_\_\_\_ Zip: \_\_\_\_\_

Name of FAST or QFO Participant Overseeing event:

\_\_\_\_\_

**(COPY OF FAST CERTIFICATE MUST BE ATTACHED TO APPLICATION)**

Phone (H): \_\_\_\_\_ Phone (W): \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **III. Please list all items on proposed menu:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IV. Anticipated number of people to be served:** \_\_\_\_\_

**Please Complete Reverse Side**

**V. Food Storage/Disposal:**

How will foods be stored at proper temperatures:

Hot: \_\_\_\_\_

Cold: \_\_\_\_\_

Method of grease disposal: \_\_\_\_\_

What are your transportation methods (if applicable): \_\_\_\_\_

What/who is your food source? \_\_\_\_\_

What are your overnight storage methods? \_\_\_\_\_

If a booth, is there running water? Yes \_\_\_\_\_ No \_\_\_\_\_ Hot? \_\_\_\_\_ Cold? \_\_\_\_\_

Date water last tested: \_\_\_\_\_

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**V. Please list the names of all volunteers:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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For NDDH Use Only

Type of Permit: Temporary \_\_\_\_\_ Annual <12 \_\_\_\_\_ Annual >12 \_\_\_\_\_

Fee Paid:\$ \_\_\_\_\_ Date rcvd: \_\_\_\_\_ Check #: \_\_\_\_\_ Receipt #: \_\_\_\_\_

Approving Sanitarian: \_\_\_\_\_ Date: \_\_\_\_\_

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