



Kenneth W. Jenkins
County Executive

Department of Health
Dr. Sherlita Amler, MD, MS
Commissioner

NOTICE TO APPLICANTS: ORIGINAL PERMIT TO OPERATE A FOOD SERVICE ESTABLISHMENT

Provisions of the Westchester County Sanitary Code requires a permit be obtained from the Department PRIOR TO the operation of a Food Service Establishment. Any food service found operating prior to inspection shall be subject to closure and legal action with additional fines. In addition, if an operator intends to make modifications to an existing food service or construct a new food service, they must submit plans and specifications to the Department for review, prior to construction. Only when you receive approval from the Department may you proceed with construction or modifications.

To apply, you are required to file the following documents with this Department
NO LATER THAN 21 DAYS PRIOR TO OPERATION.

1. Original Application for a Permit to Operate

All questions must be answered and the application must be signed and dated. Please include your email contact information.

2. Non-refundable Application Fee

Provide the application fee based on the fee category table outlined below. A combined fee is required for more than one operation. Payment can be made in the form of Check OR Money Order OR Credit Card with the enclosed authorization form. Cash Payments are **NOT** Accepted. Application fees are **NON-REFUNDABLE**.

Please make checks or money orders payable to:
WESTCHESTER COUNTY HEALTH DEPARTMENT

* Fee due may be adjusted by this Department upon inspection when the appropriate category and seating capacity are incorrect. *

Category	A	B	C
Eating Place 0-100 Seats	\$750.00	\$500.00	\$420.00
Eating Place 101-200 Seats	\$1080.00	\$740.00	\$550.00
Eating Place 201 + Seats	\$1420.00	\$940.00	\$730.00
School 0-100 Seats	\$540.00	\$420.00	\$330.00
School 101-200 Seats	\$620.00	\$540.00	\$460.00
School 201 + Seats	\$760.00	\$670.00	\$540.00

Frozen Dessert	\$25.00
Ice Manufacturer	\$160.00
Catering	\$520.00
Delicatessen	\$540.00
Commissary	\$420.00
Bakery	\$420.00
Food Vending Machine	\$50.00

3. Food Allergen Certification Course

Provide copies of all food allergen certifications.

As per Westchester County Code of Ordinances Chapter 541 – Food Allergy Restaurant Safety

541.21(b) An owner or operator of a food service establishment that offers seating for on premises food consumption shall designate no fewer than one employee in the front of the establishment and one employee in the back of the establishment as food safety officers during hours of operation who shall complete a food allergen training program approved by the Commissioner. An owner or operator of a food service establishment that does not offer seating for on premises food consumption shall designate no fewer than one employee in the establishment as a food safety officer during hours of operation who shall complete a food allergen training program approved by the Commissioner. Recertification shall be required at regular intervals as determined by the Commissioner.

The approved courses can be found on the Westchester County Health Department website at <https://health.westchestercountyny.gov/sanitation>

4. Provide Workers' Compensation & Disability Insurance

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits must provide one of the following forms to the government entity issuing the permit:

CE-200 -- Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage. This form can be found at www.wcb.ny.gov

For technical support, contact 518-485-5000.

FOR WORKERS' COMPENSATION- ACORD form not accepted

C-105.2 -- Certificate of Workers' Compensation Insurance; **OR**

U-26.3 -- The State Insurance Fund; **OR**

SI-12 -- Certificate of Workers' Compensation Self-Insurance; **OR**

GSI-105.2 -- Certificate of Participation in Workers' Compensation Group Self-Insurance

FOR DISABILITY BENEFITS

DB-120.1 -- Certificate of Disability Benefits Insurance; **OR**

DB-155 -- Certificate of Disability Benefits Self-Insurance

Any questions concerning the forms or procedure should be directed to the local NYS Workers' Compensation Board Office or the Bureau of Compliance, NYS Workers' Compensation Board at 877-632-4996.

5. Corporate Ownership

If ownership of the business is a corporation, you must file the enclosed "Certificate of Resolution". The person who signs the Renewal Application *must be* the same person named and authorized in the Certificate of Resolution. A corporate seal is not required. If your corporate officers have changed since you last filed your application, submit a list of names and addresses of the new corporate officers.

Submit all required documents **PRIOR TO OPERATION** to:

**Westchester County Health Department
Bureau of Public Health Protection
11 Martine Avenue, 12th Floor
White Plains, NY 10606
914-864-7330**

DOH-BPHP@westchestercountyny.gov

APPLICATION FOR ORIGINAL FOOD SERVICE ESTABLISHMENT PERMIT
Bureau of Public Health Protection
(Please print clearly or type)

To the Commissioner of Health:

The undersigned hereby applies for a permit to operate or maintain a business involving the following (check one or more as appropriate):

EATING PLACE	COMMISSARY	MEALS ON WHEELS
EATING PLACE SCHOOL	MOBILE FOOD COMMISSARY	SOFA FEEDING SITE
DELICATESSEN	ICE MANUFACTURER	
CATERING	RETAIL BAKERY	
FROZEN DESSERT MANUFACTURER	FOOD VENDING MACHINE OPERATION	

NEW ESTABLISHMENT UNDER CONSTRUCTION: _____
EXISTING FACILITY CHANGE OF OWNERSHIP: _____
PREVIOUS FACILITY NAME / PERMIT NUMBER: _____

1. NAME OF ESTABLISHMENT _____ PHONE _____
ADDRESS _____
_____ Municipality (Town, Village, or City) _____ State _____ Zip Code _____

NAME & MAILING ADDRESS _____
IF DIFFERENT FROM ESTABLISHMENT _____

PROVIDE CORPORATION, LLC, PARTNERSHIP INFO BELOW

2. OWNER'S NAME _____ PHONE _____
ADDRESS _____
_____ Municipality _____ State _____ Zip Code _____

TYPE OF OWNERSHIP (check one)
Individual
Partnership
Corporation
Unincorporated Association
Municipality
Limited Liability Company (LLC)

CORPORATION OFFICERS, PARTNERS, or LLC MEMBERS

Name and Title: _____ Home Address: _____

3. PROOF of WORKER'S COMPENSATION & DISABILITY INSURANCE: **ACORD FORM NOT ACCEPTED**

Please provide proper documentation of Worker's Compensation and Disability Coverage explained on cover sheet.
OR NYS EXEMPTION Form CE-200, stating that such coverage is not required.

4. a) Business Hours: _____
b) Days of week establishment is **CLOSED**: _____
c) Dates of operation if seasonal: _____
d) Number of **SEATS** in establishment: Counter / Bar _____ Table _____
e) Number of food preparation employees (including owner): _____
f) Total number of employees (include owner if he works full time): _____
g) Source of Water Supply - Public or Central Well: _____
h) Sewage Disposal - Public Sewer or Individual System: _____
i) Garbage and Refuse - Public or Private Carter: _____ Name if Private: _____
j) Pest Control Operator (Exterminator): _____
l) **Do you serve alcoholic beverages – YES or NO:** _____
m) **Total number of restrooms in facility:** _____ **Number of restrooms for public use:** _____

REQUIRED

E-MAIL ADDRESS: _____

SECOND E-MAIL ADDRESS: _____

I agree to comply with the requirements of the Westchester County Sanitary Code and the New York State Sanitary Code.

I agree to permit the taking by a duly authorized representative of the Westchester County Health Department of samples of ingredients, food, equipment, utensils, containers, or any substance on premises or in possession and used in food handling.

AUTHORIZED SIGNATURE _____

NAME (Print or Type) _____

DATE _____ TITLE _____

Section 5 of the New York State Tax Law requires that you provide a Federal Employer Identification Number or Social Security Number for tax administration purposes:

FEI OR SS # _____

OFFICE USE ONLY:

Date of Inspection _____ Date of Approval _____

Inspector's Signature & Employee Number _____

Permit Conditions _____

Risk Assessment _____

COMMENTS: _____

**CERTIFICATE OF RESOLUTION
FOR AUTHORIZATION**

The undersigned, _____ of__

Name of Corporation _____, a corporation

Duly organized and validly existing under the laws of (State) _____

Hereby certifies that the following resolution was duly adopted by the Board of Directors, of said Corporation at a meeting duly called and held on the _____ day of _____ 20 _____

Be it resolved that the Board of Directors, or President, if there is no Board of Directors, of (Name of Corporation) _____

With Offices at: _____

Hereby authorized (Name if person authorized): _____

To execute and deliver to the Westchester County Department of Health, for and on behalf of said Corporation, and application for : _____

To execute and deliver any and all additional documents which may be appropriate or desirable in Connection therewith.

The undersigned further certifies that said resolution has not been revoked, rescinded or modified and remains in full force and effect on the date hereof.

In WITNESS WHEREOF, the undersigned has duly executed this certificate on this _____ day of _____, 20 _____.

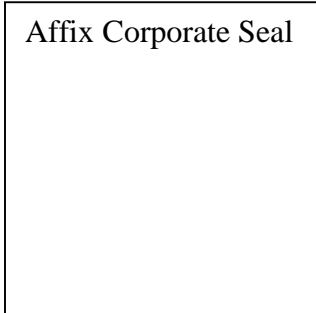
OFFICER'S SIGNATURE: _____

TITLE: _____

ACKNOWLEDGEMENT

STATE OF _____)

COUNTY OF _____): ss:



One this _____ day of _____, 20 _____, before me personally came _____ of _____ the corporation referred to in the within Certificate of Resolution, who being by duly sworn did depose and say that (s)he is _____ of said corporation and that (s)he signed his/her name thereto.

Notary Public

County

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Credit Card Payment Authorization Form

Sign and complete this form to authorize The Westchester County Department of Health to make a one-time charge to your credit card listed below.

By signing this form, you give this department permission to debit your account for the amount indicated, on or after the date this form is submitted to The Westchester County Department of Health.

Please Complete the Information Below

By signing below, I, _____, authorize the Westchester County Department of Health to charge my credit card account indicated below for the amount of _____, for the fees associated with the permit to operate a regulated facility.

Facility Name	Permit # or Plan Submittal	Permit or Plan Fee

<p>Account Type: <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard <input type="checkbox"/> AMEX <input type="checkbox"/> Discover</p> <p>Print Cardholder Name (as it appears on card): _____</p> <p>Account Number: _____ Security Code: _____</p> <p>Expiration Date: _____ Account Billing Zip Code: _____</p>
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CARDHOLDER SIGNATURE: _____ DATE: _____

Cardholder acknowledges receipt of goods and/or services in the amount indicated above and agrees to perform the obligations set forth in the cardholder's agreement with the respective issuer. I understand this is a non-refundable fee and if my application is found deficient or questionable in any way, it will cause a delay in the permit approval process.