PLAINVILLE - SOUTHINGTON REGIONAL HEALTH DISTRICT

Public Health
Prevent. Promote. Protect.

Main Office
196 NORTH MAIN STREET
SOUTHINGTON, CT 06489

Satellite Office
ONE CENTRAL SQUARE
PLAINVILLE, CT 06062

860-276-6275 ● FAX 860-276-6277 ● pshd.org

FOOD SERVICE ESTABLISHMENT APPLICATION FOR PLAN REVIEW AND PERMIT

Application Date: _____ Check one: _____New Business _____New Owner of Existing Business

Name of food service establishment: _____

Establishment address: _____

Establishment phone #'s: _____ FAX #: _____

Email: _____ After hours Emergency Phone #: _____

Mailing address (if different): _____

Name / address / phone # of Permit Holder:_____

_____

Business owner's name(s) / address(s) / phone # (if different): _____

_____

Property owner's name / phone # (if different): _____

Submit the following with this application:

- Plan review fee of $100.00 (cash or payable to Plainville-Southington Health District (PSHD)
- Proposed menu
- Equipment schedule with the manufacturer's specifications (cut sheets) for each piece of equipment proposed for use.
- Plan drawn to scale showing the layout of the food establishment, identifying the type and location of all pertinent equipment, plumbing fixtures, mechanical ventilation and a description of the type and color of floor and wall coverings.
- For new construction: provide a site plan of the property, showing location of food establishment's building, water and sewer service pipes, drive-thru areas, any outside equipment, dumpsters, water supply wells, septic system, grease interceptors, etc.
- Additional plans may be required for: Planning & Zoning, Fire, Police, Building, and Engineering

Source of water: ____ Community public: Name_____ ____Non-community _____Private well

Total # of seats at establishment: _____. Total sq. ft. of establishment: _____. Total # of employees: _____

All class 3 and 4 establishments are required to have at least one Qualified Food Operator (QFO) in a supervisory position on site. The QFO must provide this department with a copy of an acceptable certificate, from an approved testing organization, confirming the QFO passed the required examination. This department classifies all establishments.

By signing below, you attest that the information you provided above is true and accurate to the best of your knowledge. You understand that this Health District must approve any changes to the menu, equipment or kitchen layout prior to its implementation. You agree to comply with all federal, state and local laws, regulations and ordinances and clearly understand that the Food Service Permit issued by this Health District may be suspended or revoked at any time and without notice.

Signed: _____ Date signed: _____

Print Name: _____ Title: _____

FOR OFFICE USE ONLY

Plan Review fee paid: $_____ Date paid: _____ Classification: _____

Food Service Permit fee paid: $_____ Date paid: _____