

Allegany County Health Department
Environmental Health Division

Application for an Annual License to Operate a Food Service Facility

Food Service Facilities must operate in accordance with COMAR 10.15.03

The undersigned has made an application under the provisions of Health-General Article, §21-306, Annotated Code of Maryland, for a Food Service Facility License to operate the following establishment:

Facility Name (as it appears on license): _____

Physical Address: _____

Mailing Address: _____

Facility Phone: _____ Facility Fax/Email: _____

Name of Owner/Corporation/LLC/Inc., etc.: _____

Person in Charge/Position: _____ Phone: _____

Facility Hours of Operation: _____

Water Supply: Public/Municipal Private Well Sewer: Public System Private Septic

***Note:** A private water supply (well) must be tested and approved per COMAR 10.15.03.18A
(A Certificate of Potability (COP) is required for all new wells.)

Facility Type: Restaurant Mobile Unit Carry Out Bakery Other _____

If applicable: Mobile Unit Tag # _____ VIN# _____

Facility fee per year: \$300 high-priority / \$225 moderate-priority / \$150 low-priority

Maryland Health-General Code Annotated Section §1-202 requires that before any license or permit be issued to an employer to engage in an activity in which the employer may employ a covered employee, as defined in §9-101 of the Labor and Employment Article, the employer shall file with the issuing authority: a certificate of compliance with the Maryland Workers' Compensation Act; or the number of a workers' compensation insurance policy or binder.

**** Circle the number of the option which applies to you/your business and provide the requested information.**

1. Worker's Compensation Insurance Provided Ins. Company Name _____
Policy or Binder # _____
2. A waiver has been received from the MD Worker's Compensation Commission. (Attach Copy of the Waiver)
3. As provided, I am exempt from having worker's compensation insurance. (Attach Copy of the Compliance Certificate)
4. I am self-insured. Approval of self-insurance has been received from the Worker's Compensation Commission, (Attach Copy of the Compliance Certificate)
5. I am self-employed. I have no employees.

Applicant Signature: _____

Date: _____