Town of Darien

David Knauf, MPH, MS, RS
Director of Health
e-mail: dknauf@darienct.gov

HEALTH DEPARTMENT
SEASONAL FOOD SERVICE PERMIT APPLICATION

FEE:

NAME OF ESTABLISHMENT:

PLEASE TYPE OR PRINT CLEARLY

LOCATION_____

EXPECTED DATES OF OPERATION: opening:_____ closing:_____

ESTABLISHMENT TELEPHONE NUMBER_____

FAX NUMBER if available: _____

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OWNER/Primary Contact:_____Phone #_____

ADDRESS for Official Correspondence:_____

EMAIL ADDRESS_____

If there is more than one owner or contact person, please provide contact info:

Name:_____Phone#_____

Address:_____

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FOR CLASS 3 AND CLASS 4 FOOD SERVICE ESTABLISHMENTS, COMPLETE THE FOLLOWING

QUALIFIED FOOD OPERATOR (Name) _____

APPROVED TEST SOURCE _____(a copy of the QFO Certificate must be submitted)

DESIGNATED ALTERNATE _____

I hereby attest that the above information is correct

Signature of Owner/manager_____Date: _____

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For Health Department Use Only

Date of Most Recent Inspection: _____Score:_____Inspector:_____

Date Permit Issued: _____