SOUTH PLAINFIELD HEALTH DEPARTMENT

2480 Plainfield Avenue, South Plainfield, NJ 07080

RETAIL FOOD ESTABLISHMENT APPLICATION

ESTABLISHMENT *INFORMATION:*

Name: _____ Phone #: _____

Address:: _____ Fax #: _____

OWNER *INFORMATION:*

Name: _____ Phone # _____

Address: _____

MANDATORY EMAIL ADDRESS:_____

EMERGENCY CONTACT PERSON:

NAME: _____ TITLE: _____

EMERGENCY/AFTER HOURS PHONE NUMBER: _____

NON-REFUNDABLE APPLICATION FEE

ESTABLISHMENT SIZE/TYPE AND MISCELLANEOUS FEES		AMOUNT
1 - 1,000 SQ. FT.	$150.00	_____
1,001 - 5,000 SQ. FT.	$225.00	_____
5,001 - 10,000 SQ. FT.	$275.00	_____
OVER 10,000 SQ. FT.	$525.00	_____
MILK FEE	$ 50.00	_____
DRUG STORE	$ 75.00	_____
ICE (Packaged Ice Only)	$ 50.00	_____
PLAN REVIEW-New Food Estab.	$100.00	_____
LATE PENALTY	$ 50.00 PER MONTH AFTER MARCH 31ST	_____
NON-ATTENDANCE (OF FOOD COURSE)	$200.00	_____
	TOTAL AMOUNT:	_____

NOTE: **Application is to be completed and returned with a check payable to the "*South Plainfield Health Department*" by March 31st otherwise a $50.00 PER MONTH late fee will be incurred.**

FOR OFFICE USE ONLY.

LICENSE # _____ DATE ISSUED: _____

METHOD OF PAYMENT: CASH $_____ CHECK $_____ CHECK NUMBER _____