SOUTH PLAINFIELD HEALTH DEPARTMENT

2480 Plainfield Avenue, South Plainfield, NJ 07080

TEMPORARY RETAIL FOOD ESTABLISHMENT APPLICATION

ESTABLISHMENT NAME: _____

ESTABLISHMENT ADDRESS: _____

ESTABLISHMENT TELEPHONE NUMBER: _____

FAX NUMBER: _____

OWNER NAME: _____

OWNER ADDRESS: _____

OWNER TELEPHONE NUMBER: _____

DATE(S) OF EVENT: _____

NAME OF EVENT: _____

FEE SCHEDULE

LICENSE TYPE					AMOUNT
TEMPORARY EVENT (PER DAY)	*TWENTY FIVE DOLLARS*	*X*	_____ *DAYS*	=	_____
TEMPORARY EVENT (PER WEEK)	*SEVENTY FIVE DOLLARS*				_____
ONE DAY PERMIT *(VENDER/VEHICLE)*	*TWENTY FIVE DOLLARS*				_____
			TOTAL AMOUNT:		_____

FOR OFFICE USE ONLY.

LICENSE # _____ DATE ISSUED: _____

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