LFCHD Temporary Foodservice Registration Form

Name of Concession:_____

If an Event, Name of Event: _____

Owner/ Sponsoring Organization:_____

Contact Person:_____ Primary Contact Phone:_____

Location of Temporary (physical address):_____

Construction of Temporary Structure (trailer, tent, etc.):_____

Date(s) and hours of Operation: Date(s): _____Hours:_____

Date(s): _____Hours:_____

Date(s): _____Hours:_____

Date(s): _____Hours:_____

Date(s): _____Hours:_____

If for whatever reason you <u>do NOT</u> set-up or are late please call 859-231-9791 during normal working hours or after-hours / weekends / holidays call 859-335-7071 to notify the Environmental Health representative.

Food Type	Where Purchased	Method of Storage	Facilities to maintain temperature

FOOD MUST BE PREPARED ON-SITE OR AT A PERMITTED FOOD SERVICE LOCATION. IF THE FOOD IS PREPARED AT A PERMITTED FOOD SERVICE LOCATION <u>THE TEMPORARY FOOD SERVICE APPLICANT MUST</u> PROVIDE A COPY OF THE PERMIT SHOWING THE NAME OF THE PERMITTED FOOD SERVICE ESTABLISHMENT, THE PERMIT NUMBER, AND ADDRESS. ADDITIONALLY, <u>THE TEMPORARY FOOD SERVICE APPLICANT MUST</u> PROVIDE THE DATE AND TIME OF THE FOOD PREPARATION.

Permitted Food Service Name & Permit #	Address of Facility	Date	Time Prepared

_____ **DATE:**_____

SIGNATURE OF OWNER OF FACILITY

The Health Department reserves the right to prohibit the sale of specified items after reviewing the completed list. The applicant hereby grants the right of inspection to the Lexington-Fayette County Health Department representatives.

_____ **DATE:**_____

SIGNATURE OF OWNER OF FACILITY

DFS-202 (11-06)

APPLICATION FOR A PERMIT TO OPERATE A ☐ TEMPORARY ☐ FEE EXEMPT FOOD SERVICE ESTABLISHMENT AS REQUIRED BY KRS 219.011 et seq.

No person shall operate a food service establishment without having a permit issued by the Cabinet

Temporary Permit Fee: $ _____

☐ Cash ☐ Check ☐ Money Order

County: _____

Date of Application: _____

Temporary Dates of Operation: _____

Name: _____

Owner: _____

Address: _____

City: _____ State: ____ Zip: _____

FEE EXEMPT:
If changes since last application indicate:

Previous Name: _____

Previous Owner: _____

Previous Address: _____

_____
City State Zip Code

The applicant hereby grants the right of inspection to Cabinet for Health Services representatives during normal working hours.

Signature of Applicant: _____

Local Permit Number: _____

Date Received: _____

Date Approved: _____

Approved By: _____
Signature and Title