West Virginia Department of Health

 Health Department

**APPLICATION FOR A PERMIT TO OPERATE A MOBILE FOOD ESTABLISHMENT**

**(Out-of-State Vendor Residence)**

**Mobile Food Establishment Name:**

**Owner Name:**        \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phone:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Owner Mailing Address:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Owner Physical Address (if different from mailing):** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Email:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mobile Food Establishment License Plate Number:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(REQUIRED)**

|  |
| --- |
| **Person Directly Responsible for Mobile Food Establishment (Owner, Manager, Person-In-Charge):** |
| Name |       | Title |       | Phone |       |
| Mailing Address |       |

**Type of Operation**:

*TCS means time/temperature control for safety food, those requiring time/temperature controls. REQUIRED: To provide a sample menu.*

[ ]  Non-TCS Food with food preparation:

[ ]  TCS Food Prepackaged

[ ]  TCS Food with food preparation

**Please note:** Inspection of the Commissary is required as part of the opening and routine mobile food establishment inspections.

 **All mobile food establishments must comply with 64 CSR 17 Food Establishment Rule – 2013 FDA Food Code Chart 4-D FDA Food Code Mobile Food Establishment Matrix**

*I hereby certify that the above information is accurate. Further, I agree to comply with Legislative Rule 64 CSR 17, Food Establishments, and to allow the regulatory authority access to the establishment and to records as specified in that rule.*

**Date:**  **Signature of Applicant:**  \_\_\_\_\_\_\_

**For Health Department Use Only**

**Date Received:** \_\_\_\_\_\_\_\_  **Reviewed By:**  **Permit Fee:**

**Permit** **[ ]  Issued** **[ ]  Denied Date:** **Permit Number:**

**Comments:**  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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