Permit # _____

Priority: H M L

LAWRENCE COUNTY HEALTH DEPARTMENT

105 W. North Street, Mt. Vernon, MO 65712
Phone (417) 466-2201 ~ Fax (417) 466-7485
www.lawrencecohealth.com

ENVIRONMENTAL SERVICES

APPLICATION FOR FOOD ESTABLISHMENT PERMIT

According to the applicable codes and ordinances:

1. No person shall operate a food establishment that does not have a current and valid permit issued to him/her by the Administrator/Agent of this Department.
2. Establishments must comply with the requirements of the Lawrence County Health Department Food Ordinance to receive or retain such a permit.
3. A **Permit Fee** of **$100.00** must be submitted with this application.

This application is for (check all that applies):

☐ Existing facility ☐ New owner of existing facility ☐ New facility (**contact city officials pertaining to city codes**)

Water Source: ☐ Public ☐ Private **Waste Water:** ☐ Public ☐ Private

(Please check yes or no)

Does or will your establishment serve alcohol? ☐ Yes ☐ No If so, have you obtained a liquor license? ☐ Yes ☐ No

Does or will your establishment have soft serve ice cream? ☐ Yes ☐ No If so, have you obtained a frozen dessert license? ☐ Yes ☐ No

State Tax ID Number _____ County Tax ID/Mercantile License Number _____

Days of operation: S M T W T F S (circle days open) Hours of operation: From _____ a.m. to _____ p.m.

Establishment owned by: Individual Association Corporation Partnership Other (please circle one)

FOOD ESTABLISHMENT INFORMATION

Food Establishment Name: _____

Food Establishment Address: _____

Telephone No. (____) _____ Fax No. (____) _____

Email Address: _____ *Email will be used to relay recall information

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OWNER INFORMATION

Owner/Corporation: _____

If Corporation, Please List CEO: _____

Mailing Address/Billing Address: _____

Telephone No. (____) _____ Fax No. (____) _____

*Food inspection letter reports and food permit renewal notices will be sent to owner/corporation address listed above unless instructed otherwise

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SIGNATURE OF APPLICANT: _____ **DATE:** _____

PRINTED NAME OF APPLICANT: _____

Please return application to:

Lawrence County Health Department
105 W. North Street
Mt. Vernon, MO 65712

DATE RECEIVED: _____ BY: _____ FEE RECEIVED: _____

(HEALTH OFFICIAL)