

***Please complete a form for each separate operation.***

**REGISTRATION APPLICATION FOR A TEMPORARY RETAIL FOOD ESTABLISHMENT**

*Return completed form to:*

Montgomery County Health Department

1580 Constitution Row Suite G

Crawfordsville, IN 47933

765-361-4134 (fax) 765-361-3239

**410 IAC 7-24-107 PREREQUISITE FOR OPERATION**

**(a) A person may not operate a retail food establishment without first having registered with the department as required under IC 16-42-1-6.**

**(b) A retail food establishment registered with a local health department or other regulatory authority shall be considered registered with the department under IC-16-42-1-6.**

**(c) To allow verification that the retail food establishment is constructed, equipped, and otherwise meets requirements of this rule, the regulatory authority shall be notified of an intent to operate at least thirty (30) days prior to registering under this rule.**

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|  **ESTABLISHMENT OWNER INFORMATION** |
| Establishment Owner’s Name |
| Mailing Address (*number and street)* |
| City | State | ZIP Code | County |
| E-mail | Telephone Number | Fax Number |

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|  **ESTABLISHMENT INFORMATION** |
| Establishment or Organization | Certified Food Handler |
| Establishment or Organization Address (*number and street)* |
| City | State | ZIP Code | County |
| E-mail | Telephone Number | Fax Number |

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|  **EVENT INFORMATION** |
| Event Name |
| Event Contact | Telephone Number |
| Date(s) of Event (*month, day, year*) | Hour(s) of Event |
| Food to be Served |
| Location of your operation during this Event: |
| Type of structure **□** Trailer □Tent □ Cart □ Booth □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (*check one):* □ Stock truck: □ Prep truck:  |
| Providing Samples to the Public? □Yes □No |
| Food Prep / Storage at location other than Event Location? □Yes □No (*If Yes, provide Other Site address*.) (*Street) (City) (State) (ZIP Code) (County)* |
| Fees:1-3 Days: 30.00 Total Numbers of Days: \_\_\_\_\_\_\_\_\_\_\_\_Each Additional Day: $5.00 **Total Fees Due**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(Days must be consecutive)* Date *(month, day, year*) TitlePrinted name of applicant Original Signature of applicant  |