TOWN OF GUILFORD

HEALTH DEPARTMENT

50 BOSTON STREET – TOWN HALL SOUTH
GUILFORD, CONNECTICUT 06437
Phone: (203) 453.8118
Fax: (203) 453.8034

APPLICATION FOR FOOD SERVICE LICENSE

(OFFICE USE ONLY)

APPLICATION NO: ________ LICENSING YEAR: ________________ CID # ___________

FEE: $ __________________ LATE FEE $ __________________

Date: ___________

Name of Establishment: ____________________________________ Phone: ________________

Location of Establishment: ____

Name of Owner: ____________________________Cell Phone: _________________________

Address: _______________________________________Email: __________________________

Name of Operator/Manager: ______________________________ Cell Phone: _______________

Address: ____________________________________ ____Email:_________________________

Type of Water Supply: Public Water ☐ Private Well* ☐

*Establishments on private water supply wells must submit complete water analysis reports from a State Certified Laboratory prior to the issuance of an annual license.

Type of Food Service Establishment:
Restaurant: ☐ Convenience Store: ☐ Deli: ☐ Market: ☐ Caterer: ☐ Bar/Café:
☐ Skilled Nursing Facility: ☐ Day Care: ☐ Church: ☐ School: ☐ Bakery:☐ Other: ☐

Seating Capacity: ______ Number of Employees: ______ Liquor Served: Y: ☐ N: ☐

Hours of Operation: __________________________

Classification of Food Service Establishment: I: ☐ II: ☐ III: ☐ IV: ☐

Name of Qualified Food Operator (Class II, III & IV Only):________________________________
Please attach a copy of CFPM (aka QFO) certificate
Name of Designated Alternate (Class II, III & IV Only): ___________________________________
Bakery requires proof of CT DCP license. (Please attach a copy of license)

FOOD SERVICE INFORMATION:

SOURCE OF MEATS: ______________________________

SOURCE OF FISH/SHELLFISH: ______________________________

SOURCE OF MILK/CREAM: ______________________________

SOURCE OF ICE CREAM: ______________________________

SOURCE OF BREAD/PASTRIES: ______________________________

SOURCE OF PRODUCE: ______________________________

____
PRINTED SIGNATURE OF OWNER OR OPERATOR

____
WRITTEN SIGNATURE OF OWNER OR OPERATOR

NOTE:

New Businesses: Prior to submitting this application to the Health Department, it must be submitted to the Office of the Assessor. Applications received without this notification will not be processed

FOR OFFICE USE ONLY

APPROVED: ______________________________ DATE: ______________
(Assessor)