

**Application for a Permit to Operate**

Annual Permit

Mail to: Tioga County Environmental Health  
1062 State Route 38  
P.O. Box 120  
Owego, NY 13827

Mobile Food Unit \$ 114.00

Complete all items that apply to your establishment (all applicants must complete Sections A, B, G and H), sign on the back page and return with the appropriate fee at least 30 days prior to the expected opening date to:

**SECTION A: Facility Information (Entire section must be completed by all applicants.)**

Facility name \_\_\_\_\_  
 Facility address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Telephone no. (\_\_\_\_) \_\_\_\_\_ Fax no. (\_\_\_\_) \_\_\_\_\_  
 Municipality \_\_\_\_\_ [T] [V] [C] Capacity [\_\_\_\_\_] Facility Status [ ] Profit [ ] Non-profit  
 Facility Type [\_\_\_\_\_] Indicate days operation is open S M T W T F S  
 Expected opening date [ ][ ]/[ ][ ] Expected closing date [ ][ ]/[ ][ ] Hours of operation [ ][ ] [ ][ ] AM PM [ ][ ] [ ][ ] AM PM  
 Month/Day Month/Day Open Close

**Water Supply**      **Sewage System**      **Number of operations under this registration**  
 Public (municipal)     Public (municipal)     Indoor Pools     Bathing Beaches     Food Services     Day Camps  
 Private (onsite)       Private (onsite)       Outdoor Pools     Spa Pools     Recreational Aquatic Spray Grounds  
 Tanning Devices

**SECTION B: Operator/Owner Information (Entire section must be completed by all applicants.)**

Legal **operator** or operating corporation \_\_\_\_\_  
 (If corporation or partnership, Section F must be completed.)  
 Person in charge \_\_\_\_\_ Telephone no. (\_\_\_\_) \_\_\_\_\_ Fax no. (\_\_\_\_) \_\_\_\_\_  
 Permanent address \_\_\_\_\_ Email address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Employee Identification Number [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ] [ ][ ]  
 Or Social Security Number [ ][ ] [ ][ ] [ ][ ]-[ ][ ] [ ][ ]-[ ][ ] [ ][ ] [ ][ ] [ ][ ]  
 Owner \_\_\_\_\_ Telephone (\_\_\_\_) \_\_\_\_\_  
 Permanent address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECTION C: Complete for temporary food service establishments only (attach additional sheets as necessary).**

Name and location of event \_\_\_\_\_

Name of Foods      Supplier of ingredients      Where and how foods will be prepared and served

Name of Foods	Supplier of ingredients	Where and how foods will be prepared and served

**SECTION D: Complete for mobile food service establishments or pushcarts only.**

Type of vehicle  Motorized  Pushcart  Other (specify) \_\_\_\_\_

Motor vehicle license number (motorized vehicles only) \_\_\_\_\_

Commissary name \_\_\_\_\_ Telephone No. (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

List on a separate sheet of paper the type of food and beverages served.

**SECTION E: Food and beverage machines only. Attach a list of all machine locations and food dispensed.**

**SECTION F: Partners and Corporate Officers**

List all partners and corporate officers in the operation of the facility. Include vice president(s), secretary, treasurer. Attach DOH-2135 (or additional sheets) as necessary.

Name	Title	Address	Telephone No.

**SECTION G: Workers' Compensation and Disability Insurance (All applicants must complete this section.)**

Check the appropriate lines and submit copies of the following documentation with the application to document compliance with the Worker's Compensation Law:

A. Workers Compensation and Disability Insurance Coverage **Provided**

Workers Compensation

Form C-105.2 – Certificate of Worker's Compensation Insurance **OR**

Form U-26.3 – Certificate of Workers' Compensation Insurance **OR**

Form SI-12 – Certificate of Workers' Compensation Self-Insurance **OR**

GSI – 105.2 – Certificate of Participation in Workers' Compensation Group Self-Insurance

**AND**

Disability Insurance

DB-120.1 - Certificate of Disability Benefits **OR**

Form DB-155 – Certificate of Disability Benefits Self-Insurance

B. Workers Compensation and Disability Insurance Coverage **NOT Provided**

Form CE-200 – Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

**SECTION H: Signature (Entire section must be completed by all applicants.)**

**FALSE STATEMENTS MADE ON THIS APPLICATION ARE PUNISHABLE UNDER THE PENAL LAW.**

**Failure to sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code.**

Signature of individual operator or authorized official \_\_\_\_\_

Print name of person signing \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

**SECTION I: FOR OFFICE USE ONLY**

Permit issuance recommended?  Yes  No Permit Effective Date [ ][ ][ ] Permit Expiration Date [ ][ ][ ]

Conditions of approval \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_