



NEW MILFORD HEALTH DEPARTMENT
10 Main Street
New Milford, CT 06776
(860) 355-6035 Fax (860) 210-2664

Temporary Food Service Establishment Application

Name of Organization/Operation: _____

Address: _____ Phone: (____) _____ - _____

Contact Person: _____ Phone: (____) _____ - _____

E-mail: _____ Fax: (____) _____ - _____

Event Location: _____

Type of Operation : (check one)

- ITINERANT VENDOR STATE- OWNED TEMPORARY PRIVATE INSTITUTION
 NON-PROFIT OTHER: (specify) _____

If NON-PROFIT, Please provide proof

If ITINERANT VENDOR – plate number _____

Dates of Proposed Operation FROM _____ TO _____

Types of Food Served:

Submit complete menu with application. If menu not yet prepared, list all food items served below. Use the back of this form if more space is needed. Menu need not be submitted if done so previously and there are no changes.

The undersigned is aware of and agrees to comply with the food service regulations of the State of Connecticut and the Town of New Milford.

SIGNATURE _____ DATE ____ / ____ / ____

HEALTH DEPARTMENT USE

\$25.00 Fee Paid _____ Non-Profit (No Fee Required) _____

Approved: License Picked-up License Mailed