

SOUTH CENTRAL HEALTH DISTRICT

196 North Main St. Southington, CT 06489 860.276.6275 | **schd-ct.org**

ITINERANT FOOD VENDOR APPLICATION

Date			Annual Fee	\$225.00
Complete	e the application include	all information requested	d on the checklis	t.
Name of Food Vend	ing Business			
Business Owner's N	ame			
Address				
Phone		Email		
Operator's name, ad	ddress, phone & email (if di	fferent then owner):		
Vehicle/Trailer				
Make	Model	License Plat	e #	
Proposed Location	(s)			
Days and Hours of C Property Owner; s N		Number(s) if operating busine	ess on private prop	erty:
(Provide a le	tter from property owner allowing	g you to conduct a food vending but	siness on their property	<u></u>
information provided abo		tes or regulations pertinent to your immediately notify this department d without prior notice.		
Signature Owner/Operator		Print Name		Pate
	FOR DI	STRICT USE ONLY		
Date Total Fee Paid \$	☐ Casii ☐ Check # ☐ Money Order	Fee Code(s)	Classification	
Police Department approval	☐ Yes ☐ No Comments:			
Planning/Zoning Approval	☐ Yes ☐ No Comments:			
Sanitarian Signature		Date Approved	Date Denied	