***NODAWAY COUNTY HEALTH CENTER***

***APPLICATION FOR TEMPORARY FOOD VENDOR PERMIT***

***Application Due 3 Days Prior to Event***

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| ***Applicant Information*** |
| ***Company/Organization Name:*** |
| ***Applicant Name:*** | ***Nonprofit: Yes No*** |
| ***Street Address:*** | ***City/State/Zip:*** |
| ***Phone:*** | ***Email:*** |
| ***Name of Event:*** |
| ***Event Location:*** |
| ***Person in Charge:*** | ***Phone:*** |
| ***Type of Food Served:*** |
| ***Please circle dates of event.******Month*** *JAN FEB MAR APR MAY JUN* *JUL AUG SEP OCT NOV DEC****Times of Operation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** | ***Date(s) of Operation*** *(circle all that apply)* *1 2 3 4 5 6 7 8 9 10 11 12* *13 14 15 16 17 18 19 20 21 22* *23 24 25 26 27 28 29 30 31* |
| ***Temporary Permits are limited to single events not exceeding 14 consecutive days.******Temporary Permits are only valid for the dates that appear on the permit.******All foods offered for consumption must be prepared at the permitted location or transported from an approved source. No home prepared foods may be offered for consumption.*** |
| *I hereby certify that the information provided is correct. I have a received a copy of the requirements for approval to operate a temporary food establishment, and will ensure that the requirements are met.****Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |
| ***SUBMIT COMPLETED APPLICATION TO:***NACCHOLogo***NODAWAY COUNTY HEALTH CENTER******2416 S. MAIN******MARYVILLE, MO 64468******Phone # : (660) 562-2755******Fax # : (660) 562-4995*** |
| ***OFFICE USE ONLY****Temporary Event Fee* ***Waived******FEE PAID:\_\_\_\_\_\_\_\_\_\_\_ NCHC REPRESENTATIVE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** |