

**SEND APPLICATION TO:**

Worcester County Health Department
13070 St. Martin's Neck Rd.
Bishopville, MD 21813

Date _____
410-352-3234 or
410-641-9559

Checks payable to: Worcester County Commissioners

APPLICATION FOR LICENSE TO OPERATE A FOOD SERVICE FACILITY

Application is hereby made to operate a food service facility in accordance with COMAR 10.15.03 Regulations Governing Food Service Facilities.

PLEASE PRINT CLEARLY OR TYPE

FACILITY NAME _____

FACILITY ADDRESS _____

CITY _____ **STATE** _____

ZIP CODE _____

NEW OWNER: ☐ YES ☐ NO **FORMER NAME** (if any) _____

OWNER(S) OF BUSINESS _____ (If LLC or Corp – Also List Members)

OWNER E-MAIL _____ **OWNER PHONE** _____

OWNER'S MAILING ADDRESS _____

HOURS OF OPERATION _____

FACILITY PHONE NUMBER _____

FACILITY INFORMATION (check all applicable boxes)

- | | |
|---|--|
| ☐ Full Service Restaurant/Lounge | ☐ Mobile Unit Year _____ Make _____ |
| ☐ Confections (Candy, Ice Cream) | Model _____ Tag# _____ |
| ☐ Grocery-Market/Deli | ☐ Non-profit kitchen (church, fire co., school, etc.) |
| ☐ Market/Prepackaged | ☐ Carry Out Available |
| ☐ Bakery | ☐ Carry Out Only |
| ☐ Bar/Lounge/Liquor Store | ☐ Soft Serve Ice Cream/Yogurt |
| ☐ Other | |

SEATING

Inside ☐ Yes ☐ No Outside ☐ Yes ☐ No

LENGTH OF OPERATION

☐ All Year

ALCOHOLIC BEVERAGE LICENSE

☐ Seasonal From _____ To _____ (Month/Date)

☐ Yes ☐ No

WATER SUPPLY ☐ Public ☐ Private

SEWERAGE ☐ Public ☐ Private

Please complete and sign both front and back pages. If application is not complete, it will be returned to you.
Allow 10 business days for processing of your food service operating license.

APPLICANT'S SIGNATURE _____ **POSITION** _____

AMOUNT OF FEE ENCLOSED ☐ \$330.00 (High/Moderate) ☐ \$150.00 (Low) ☐ \$100.00 (Prepackaged)

☐ \$300 (High/Moderate Reciprocal) ☐ \$150 (Low/Prepackaged Reciprocal) ☐ N/A

☐ \$50.00 per Day Late Fee (Maximum Late Fee - \$300.00)

*****PLEASE MAKE CHECKS PAYABLE TO WORCESTER COUNTY COMMISSIONERS*****

OFFICE USE ONLY

Change of Ownership ☐

I.D. Number _____ Sanitarian _____ Priority Assessment _____

Date Issued _____ Date Expires _____ Workmen's Comp Statement _____

Comments _____

Env. Programs
Approval



WORCESTER COUNTY HEALTH DEPARTMENT

Main Office: 6040 Public Landing Rd. | P.O. Box 249 | Snow Hill, MD. 21863-0249 | 410-632-1100

REBECCA L. JONES, RN, BSN, MSN | HEALTH OFFICER



STATEMENT OF WORKERS' COMPENSATION INSURANCE

Maryland Health-General Code Annotated Section 1-202 requires that before any license or permit be issued under the Health-General Article to an employer to engage in an activity in which the employer may employ any individual, the employer must file with the issuing authority a certificate of compliance with the State Workers' Compensation Laws indicating the employer's Worker' Compensation insurance policy or binder number. Waiver or certificate of compliance can be obtained by calling the Workers' Compensation Commission at 410-864-5100

CIRCLE the number of the option below which applies to you, provide the requested information, sign and date the form, and return it with the attached application. (***NOTE: License cannot be issued without completion of this form.***)

1. I have Workers' Compensation insurance.

Insurance Company _____ Policy/Binder No. _____

Agent _____ Phone Number _____

2. A waiver has been received from the Workers' Compensation Commission. (A COPY OF THE WAIVER MUST BE ATTACHED BEFORE A LICENSE WILL BE GRANTED.)

3. As provided by Maryland Annotated Code Article 101, I am exempt from having Workers' Compensation insurance. (Circle option a or b below.)

a. Attached is a copy of the certificate of compliance.

b. I have applied for a certificate of compliance from the Workers' Compensation Commission on _____. Copy of certificate will be forwarded to Worcester County Office of Environmental Health upon receipt.

4. I am self-insured. Approval of self-insurance has been received from the Workers' Compensation Commission. (A COPY OF THE CERTIFICATE OF COMPLIANCE MUST BE ATTACHED BEFORE A LICENSE WILL BE GRANTED.)

5. I have no employees; therefore, I am not required to carry Workers' Compensation insurance.

SIGNATURE/TITLE

DATE

FACILITY NAME

TITLE

BERLIN HEALTH CENTER 410-629-0164 | DENTAL CENTER 410-641-0240
ENVIRONMENTAL HEALTH 410-352-3234/410-641-9559 | MARYLAND ACCESS POINT 410-632-9915
OCEAN CITY HEALTH CENTER 410-289-4044 | POCOMOKE HEALTH CENTER 410-957-2005
TTY MARYLAND RELAY SERVICE 1-800-735-2258 | W.A.C.S. CENTER 410-213-0202