

# 2016

## FAIR LAWN HEALTH DEPARTMENT

**FOOD ESTABLISHMENT LICENSE: NEW FOOD ESTABLISHMENT or CHANGE OF OWNERSHIP**  
**APPLICATION FOR (Circle One):** restaurant, deli, luncheonette, kitchen, bagel shop, cafeteria, bakery, food store

Food Establishment Name: \_\_\_\_\_

Food Establishment Address: \_\_\_\_\_

Business Phone: (\_\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_\_) \_\_\_\_\_

Email address: \_\_\_\_\_

Hours of Operation (i.e.: 9am to 5pm) Sun \_\_\_\_\_ m to \_\_\_\_\_ m Mon \_\_\_\_\_ m to \_\_\_\_\_ m Tues \_\_\_\_\_ m to \_\_\_\_\_ m

Wed \_\_\_\_\_ m to \_\_\_\_\_ m Thurs \_\_\_\_\_ m to \_\_\_\_\_ m Fri \_\_\_\_\_ m to \_\_\_\_\_ m Sat \_\_\_\_\_ m to \_\_\_\_\_ m

How long before and after the Hours of Operation is a Person in Charge present in the establishment in case of emergency notification?: \_\_\_\_\_ hours before opening. \_\_\_\_\_ hours after closing.

Trade Name & Address (if different from above): \_\_\_\_\_

Name of Owner: \_\_\_\_\_ Owner's Home Phone#: \_\_\_\_\_

Owner's home address: \_\_\_\_\_

Name of Second Owner: \_\_\_\_\_ Second Owner's Home Phone#: \_\_\_\_\_

Second Owner's home address: \_\_\_\_\_

Person-in-charge (i.e. owner/manager) of establishment to be contacted in case of emergency: \_\_\_\_\_

Home phone number of person-in-charge: \_\_\_\_\_ Cell#: \_\_\_\_\_

Number of food handlers employed in establishment: \_\_\_\_\_

The cost for food establishment license is as follows:

1-9 food handlers -- \$195    10-19 food handlers -- \$250  
20-29 food handlers -- \$325    30 or more food handlers -- \$400

I hereby certify that this food preparation & storage facility will be kept in proper sanitary manner, according to regulation NJAC 8:24 - 1 et seq sanitary requirements. This license expires on December 31<sup>st</sup> & must be renewed annually.

1. License fee submitted for this location: \$ \_\_\_\_\_
2. \_\_\_\_\_ Initial Food Handler Registrations at \$35 each = \$ \_\_\_\_\_
3. **\$50 Pre-operational inspection fee: \$50**
4. Total amount of fees submitted for this location: \$ \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of Applicant

**Please make check payable to the *Borough of Fair Lawn* and mail to:**  
**Fair Lawn Health Department**  
**8-01 Fair Lawn Avenue**  
**Fair Lawn, New Jersey 07410**

\*\*\*\*\* (Do not write below this line) \*\*\*\*\*

Date payment received: \_\_\_\_\_ Date issued: \_\_\_\_\_ Health Officer's Approval: \_\_\_\_\_

Fee Paid: \$ \_\_\_\_\_ Pre-op Fee: \$ \$50 Total Paid: \$ \_\_\_\_\_ FE #'s: \_\_\_\_\_