

**2016**  
**FAIR LAWN HEALTH DEPARTMENT**  
**PRE-PACKAGED FOOD LICENSE**  
**APPLICATION**

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

Trade Name: \_\_\_\_\_

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

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

\_\_\_\_\_

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

Phone number of person-in-charge: \_\_\_\_\_ Cell#: \_\_\_\_\_

Do you sell any of the following? (Circle all that apply): Buttered Rolls Prepared on Premises

Milk & Other Dairy Products      Ice Cream & Frozen Desserts      Hot Coffee by the cup

THE FEE FOR A LICENSE TO SELL PRE-PACKAGED FOOD IS \$110.00  
or \$150 if potentially hazardous foods are sold

**IF APPLICATION WILL BE RECEIVED AFTER JANUARY 15, 2016 THE FEE IS \$160**  
**Or \$200 if potentially hazardous foods are sold**

Please be aware that a separate license is required for any food or beverage vending machines located on the premises.

Please contact the Fair Lawn Health Department to obtain a vending machine license application.

I hereby certify that only pre-packaged food is sold at this site. The food sold is checked regularly for expiration dates and is kept in a sanitary manner. This license expires on December 31<sup>st</sup> and must be renewed annually.

1. 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: \$ \_\_\_\_\_ Late Fee Paid: \$ \_\_\_\_\_ Total Paid: \$ \_\_\_\_\_ PP #'s: \_\_\_\_\_ PP/PHF #'s: \_\_\_\_\_

Risk Type \_\_\_\_\_