ERIE COUNTY DEPARTMENT OF HEALTH

DIVISION OF ENVIRONMENTAL HEALTH SERVICES
503 Kensington Avenue, Buffalo, N.Y. 14214

APPLICATION FOR A PERMIT TO OPERATE A TEMPORARY FOOD SERVICE ESTABLISHMENT

SUBMIT THIS APPLICATION LEAST 5 DAYS BEFORE THE FIRST DAY OF OPERATION (PLEASE PRINT OR TYPE)

1. EVENT: **ERIE COUNTY FAIR 2020** AUGUST 12 - 23, 2020
5600 MCKINLEY PARKWAY
HAMBURG, NY 14075

2. STAND INFORMATION:
Name of Food Stand: _____
Foods to be served: _____
Stand Location: _____

3. OPERATOR:
a) Owner /Corporation _____
b) Corporation Officer _____ Title _____
c) Address _____City/Town _____
d) State _____Zip Code _____Phone (____) _____Fax (____)_____
e) Responsible Person_____ Email: _____

4. WORKER'S COMPENSATION/DISABILITY BENEFITS INSURANCE:
Proof of coverage or exemption is required for permit issuance
WC Carrier _____
Policy # _____ Effective Dates: _____

DBI Carrier: _____
Policy #: _____ Effective Dates: _____

5. FEE REQUIRED: Make Checks Payable to **Erie County Commissioner of Finance**

No. of Days of Operation at Event	5 or more days prior to event:		4 days or less prior to event:	
1-3 Days	$106	☐	$146	☐
4-7 Days	$120	☐	$150	☐
8 – 14 Days	$150	☐	$190	☐
Frozen Dessert Machine			$25.00	☐

Total Fee Due
$_____

6. SIGNATURE Print Name _____ Title:_____

Signed: _____ Date: _____

IF THIS APPLICATION IS APPROVED, THE UNDERSIGNED APPLICANT HEREBY AGREES TO OPERATE THE TEMPORARY FOOD SERVICE ESTABLISHMENT DESCRIBED ABOVE IN COMPLETE COMPLIANCE WITH THE REQUIREMENTS OF PART 14 OF THE NEW YORK STATE SANITARY CODE. APPLICANT ALSO ACKNOWLEDGES THAT WORKERS COMPENSATION AND DISABILITY INSURANCE ARE IN FORCE AS REQUIRED.

INSTRUCTIONS FOR COMPLETING APPLICATION FOR
A PERMIT TO OPERATE A TEMPORARY FOOD SERVICE ESTABLISHMENT

Item 1.	**EVENT**	**ERIE COUNTY FAIR 2020**
Item 2.	**FOOD STAND**	Name of food stand for this event Indicate the foods that will be served at this stand Indicate location of stand at the event
Item 3.	**OWNER/OPERATOR**	a. Name of owner of business or corporation b. Name of Corporation Officer and title c.&d. Indicate address and phone/fax number of Operator e. **Name of Responsible Person** – name and title of individual responsible for the operation who may be contacted in the event of an emergency. Email address if available
Item 4.	**WORKER'S COMP/DISABILITY BENEFITS INFO**	Indicate Workers Comp/Disability Insurance Information
Item 5.	**FEE REQUIRED**	Check the box that is appropriate and make check payable To: **Erie County Commissioner of Finance**
Item 6..	**SIGNATURE**	Print name and title of the person signing this application Signature and date

SEND APPLICATION AND PAYMENT TO:

ERIE COUNTY HEALTH DEPARTMENT
503 KENSINGTON AVENUE
BUFFALO, NY 14214