

**MAYOR
DAVID R. MARTIN**



Anne T. Fountain, MPH
Director of Health & Social Services
203-977-4396

**CITY OF STAMFORD
DEPARTMENT OF HEALTH & SOCIAL SERVICES
888 WASHINGTON BOULEVARD
STAMFORD, CT 06901**

TO: All Temporary Food Service Vendors

RE: Submission of Temporary Food Service Applications

Dear Vendors:

As indicated in the Stamford Health Department "Checklist for Temporary Food Service Booths," a completed set of the temporary food service application forms must be submitted a minimum of 14 days prior to the event with 5 or less food booths; more than 5 food booths a minimum of 21 days prior to the event, the application form must be submitted to the Stamford Health Department.

Verbal phone contacts to members of the Stamford Health Department are not a substitute for a written application which must be submitted prior to the event as indicated above.

Sincerely,

Anne T. Fountain, MPH
Director of Health & Social Services



**Department of Health & Social Services
Stamford Government Center
888 Washington Boulevard
P.O. Box 10152
Stamford, CT 06904-2152**

PLEASE TYPE OR PRINT LEGIBLY:

By providing the following information, you will assist in identifying potential public health problems that might occur during your event. Solving these problems in advance will provide the opportunity for a successful and smooth operation.

1. Name of event : _____

 2. Dates of event: _____

 3. Location of event: _____

 4. Time of set-up: _____

 5. Time of event: _____

 6. Name of sponsoring organization or company: _____

 7. a. Number of Food Booths: _____
 b. Names and contact numbers: _____

 8. Expected number of patrons: _____

 9. Names of event coordinators/responsible individuals on-site:

-

10. Describe proposed Rest Room facilities (type, number, location):

11. Will electricity be provided to the food booths? ____yes ____no

12. Describe potable water supply:

13. Describe wastewater disposal system:

14. Describe garbage disposal:

15. MENU: List ALL items. Any changes must be submitted and approved by Stamford Health Department: _____

16. Will any foods be prepared at home? Please list: _____

17. Fill out Attachments A &/or B: (Refer to pages 3 & 4)

18. Draw a sketch of the event area (refer to pages 5 & 6): include toilet facilities, garbage facilities, all food booths and preparation sites on the grounds of the event including all equipment, hand washing facilities, work tables, refrigerators, dry goods storage, & etc. No changes on this approved plan can be made unless the Health Department is notified and changes are given approval.

19. I certify that I am familiar with Food Service Regulations of the Stamford Health Department and the above-described establishment will be operated and maintained in accordance with the regulations.

Applicant's Signature

Date

MAYOR
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Director of Health & Social Services
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CITY OF STAMFORD
DEPARTMENT OF HEALTH & SOCIAL SERVICES
888 WASHINGTON BOULEVARD
STAMFORD, CT 06901

Application for Food Service Establishment License
Year _____

Name of Establishment: _____

Address of Establishment: _____

Phone : _____

Name of Owner and/or Chief Corporate Officer & Title:

Name of Company: _____

Home and/or Business headquarters address of
Owner and/or Chief Corporate Officer:

Seating Capacity: _____ (Exact number of seats)

Liquor Served: Yes _____ No _____

Qualified Food Operator: Yes _____ No _____ ; if yes Total _____

Annual License Fee (Check appropriate category)	
Seating Capacity (1 - 15)	\$ 21.00
Seating Capacity (16 - 25)	\$ 49.00
Seating Capacity (26 - 50)	\$105.00
Seating Capacity (51 - 100)	\$210.00
Seating Capacity (101-150)	\$315.00
Seating Capacity (151 - 200)	\$420.00
Seating Capacity (201-250)	\$525.00
Seating Capacity (251-300)	\$630.00
Seating Capacity (> 300)	\$735.00
Take-out	\$210.00
Caterers	\$315.00
Itinerant Food Vendor	\$525.00
Temporary License 14 days	\$ 49.00
Public & Private Schools	\$ 1.00
Non Profit Org. & Churches	\$ 1.00
Temp. License (Non-profit)	\$ 1.00
Itinerant Food Vendor, Veteran	\$.00

Failure to notify the Health Department of any transfer or change of ownership or any closing of business within 48 hours of such change may result in immediate closure or delayed establishment licensure.

Signature of { } Owner or { } Manager: _____ Date: _____

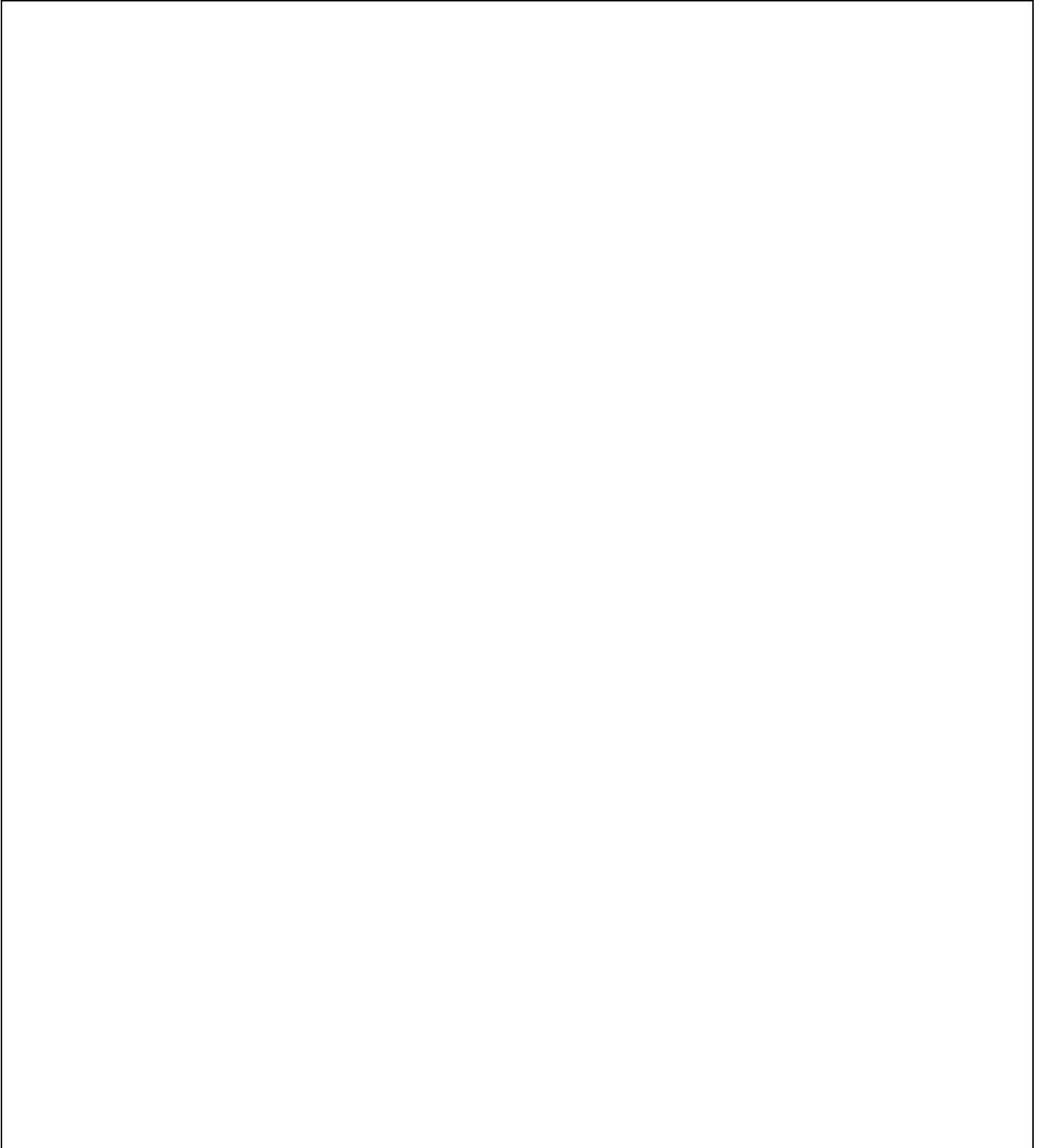
Inspected by: _____ DATE: _____ Approved by: _____

Director of Health

NOTES:
Application and license fee must be received by the Health Department before January 1, 20____ deadline. Make check payable to "CITY OF STAMFORD" Department of Health, 888 Washington Boulevard, P.O.Box 10152, Stamford, Ct 06904-2152. Your license will be mailed to you after processing.

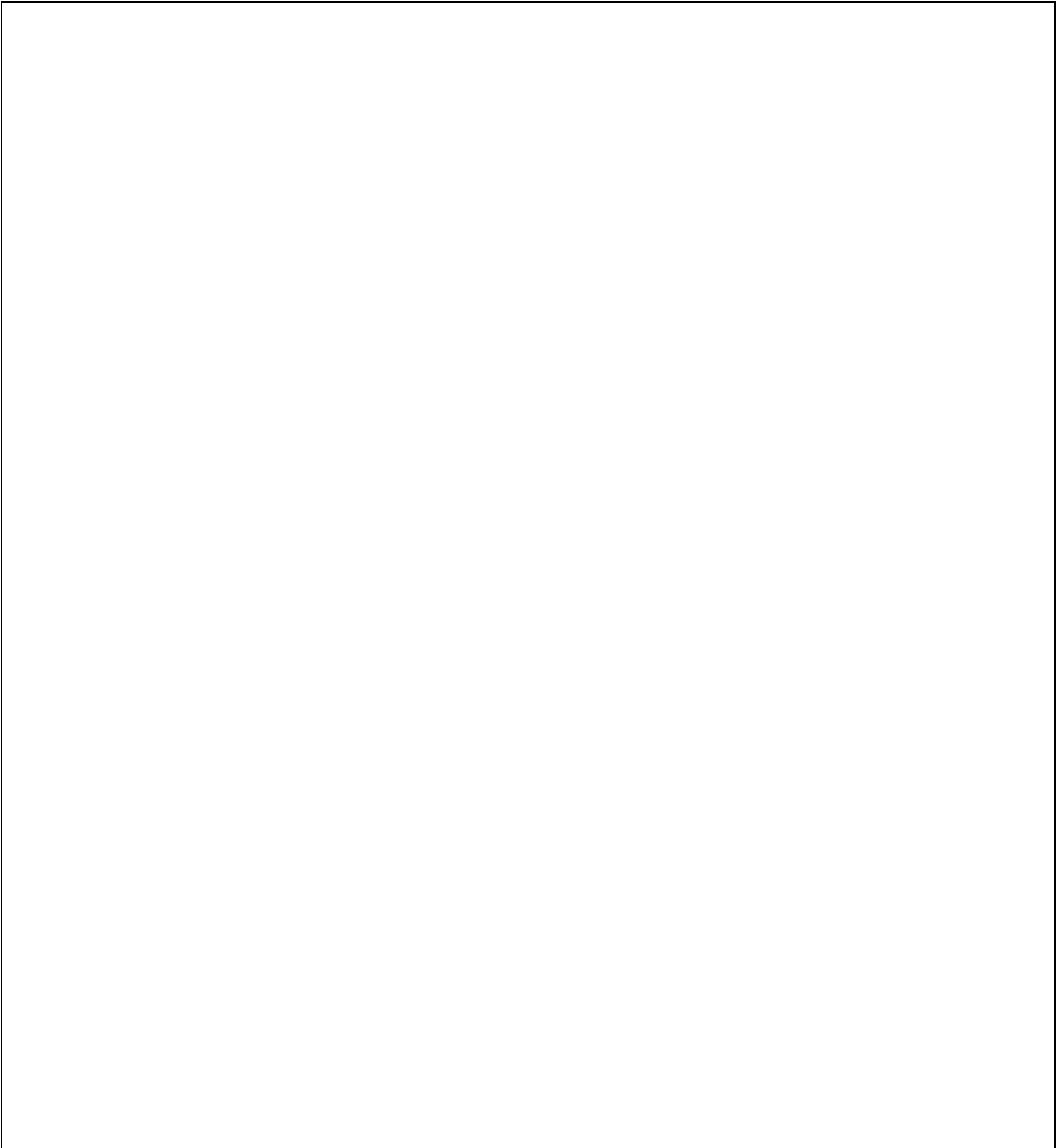
Sketch Sheet I

In the following space, provide a drawing of the Temporary Food Establishment, identify and describe all equipment including cooking and cold holding equipment, hand washing facilities, work tables, dishwashing facilities, food and single service storage, garbage containers, and customer service areas.



Sketch Sheet II

In the following space, provide a drawing of the entire Temporary Event Area including locations of the toilet facilities, garbage facilities, common use dishwashing facilities, and all food preparation and service areas on the grounds/site of the Temporary Food Event.

A large, empty rectangular box with a thin black border, intended for a hand-drawn sketch of the Temporary Event Area. The box occupies most of the page below the instructions.

ATTACHMENT A
Food Preparation at the Temporary Food Establishment

List each food item and identify where each preparation procedure which will take place at the Temporary Food Establishment.

FOOD	THAW How?/Where?	CUT/WASH ASSEMBLE Where?	COLD HOLDING How?/Where?	COOK How?/Where?	HOT HOLDING How?/Where?	REHEATING How?/Where?	COMMERCIAL PREPORTIONED PACKAGE

