



# Division of Environmental Health

403 S. 7<sup>th</sup> Street; Rm 248, Denton, MD 21629

Health Officer, Robin L. Cahall, BHS, CPH

## Caroline County Health Department Mobile Reciprocity Food Permit Application

Application is hereby made to operate a mobile food service operation in accordance with COMAR 10.15.03

**SUBMIT COMPLETED FORM 3-WEEKS PRIOR TO OPERATING IN CAROLINE COUNTY**

The Caroline County Health Department reserves the right to deny an incomplete or fraudulent license application.

**A license application received without a fee will not be processed.**

Do you have a "County of Origin: Mobile Food License?  Yes  No (If no, you do not qualify for reciprocity)

If you selected "Yes", please provide the following documents for approval of reciprocity mobile license:

- Copy of Food License issued by the "County of Origin" and most recent Inspection Report
- Menu and Approved HACCP Plan
- Commissary or Base Operation Authorization document
- Copy of Vehicle Registration
- Completed statement for Worker's Compensation Compliance

Mobile Type:  Mobile Trailer Unit  Mobile Truck  Push Cart  Pre-Packaged Ice Cream Only

Please print clearly

Facility Name:	Owner's Name:
Business Name: (INC. or LLC)	Mailing Address:
Mobile Tag #:	City, State, ZIP:
Name of Base of Operation:	Phone Number:
Base of Operation Address:	Email Address:
Vehicle License Plate Tag #:	Vehicle VIN #:
Business Operation: <input type="checkbox"/> Permanent/Year-Round  <input type="checkbox"/> Seasonal (Operating Dates) _____	Days of Operation:  Times of Operation:
Water Supply: <input type="checkbox"/> Public <input type="checkbox"/> Private	Sewage Disposal: <input type="checkbox"/> Public <input type="checkbox"/> Private
Set up location(s):	

I have examined and read the above application and attached requirements and I agree to comply with all applicable laws, regulations, and requirements including, but not limited to, the State of Maryland and Caroline County in operating a food service facility. I understand that falsification of this application may result in the denial, suspension, or revocation of the license.

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

**Health Department Use Only**

Date Received:	<input type="checkbox"/> Approved <input type="checkbox"/> Denied	Priority Assessment: <input type="checkbox"/> High Priority <input type="checkbox"/> Moderate Priority <input type="checkbox"/> Low Priority
Fee Due:	Date Issued (if approved):	Reviewed By:
Receipt #:		