

LFCHD Temporary Foodservice Registration Form

Name of Concession: _____

Owner/ Sponsoring Organization: _____

Contact Person: _____ Primary Contact Phone: _____

Location of Temporary (physical address): _____

Construction of Temporary Structure (trailer, tent, etc.): _____

Date(s) and hours of Operation: Date(s): _____ Hours: _____

Date(s): _____ Hours: _____

Date(s): _____ Hours: _____

Date(s): _____ Hours: _____

Date(s): _____ Hours: _____

If for whatever reason you do NOT set-up or are late please call 859-231-9791 during normal working hours or after-hours / weekends / holidays call 859-335-7071 to notify the Environmental Health representative.

Food Type	Where Purchased	Method of Storage	Facilities to maintain temperature

FOOD MUST BE PREPARED ON-SITE OR AT A PERMITTED FOOD SERVICE LOCATION. IF THE FOOD IS PREPARED AT A PERMITTED FOOD SERVICE LOCATION THE TEMPORARY FOOD SERVICE APPLICANT MUST PROVIDE A COPY OF THE PERMIT SHOWING THE NAME OF THE PERMITTED FOOD SERVICE ESTABLISHMENT, THE PERMIT NUMBER, AND ADDRESS. ADDITIONALLY, THE TEMPORARY FOOD SERVICE APPLICANT MUST PROVIDE THE DATE AND TIME OF THE FOOD PREPARATION.

Permitted Food Service Name & Permit #	Address of Facility	Date	Time Prepared

SIGNATURE OF OWNER OF FACILITY

DATE: _____

The Health Department reserves the right to prohibit the sale of specified items after reviewing the completed list. The applicant hereby grants the right of inspection to the Lexington-Fayette County Health Department representatives.

SIGNATURE OF OWNER OF FACILITY

DATE: _____

APPLICATION FOR A PERMIT TO OPERATE A TEMPORARY FEE EXEMPT
 FARMER'S MARKET TEMPORARY FOOD SERVICE ESTABLISHMENT
AS REQUIRED BY KRS 217.005 TO 217.992

COPY OF CERTIFICATE OF TRAINING ATTACHED

Temporary Permit Fee: \$ _____
<input type="checkbox"/> Cash <input type="checkbox"/> Check <input type="checkbox"/> Money Order

County: _____

Date of Application: _____

Temporary Dates of Operation: _____

Name: _____

Owner: _____

Address: _____

City _____ State _____ Zip Code _____

FEE EXEMPT: If changes since last application indicate:
Previous Name: _____
Previous Owner: _____
Previous Address: _____
City _____ State _____ Zip Code _____

The applicant hereby grants the right of inspection to Cabinet for Health and Family Services representatives during normal working hours.

Signature of Applicant: _____

Local Permit Number: _____

Date Received: _____

Date Approved: _____

Approved By: _____

Signature and Title