PLATTE COUNTY HEALTH DEPARTMENT
ENVIRONMENTAL HEALTH DIVISION
212 Marshall Road Platte City, MO 64079
Phone: (816) 858-2412 Fax: (816) 858-2087
Email: Food@plattehealth.com
www.plattecountyhealthdept.com

For office use only
Issue Date: _____
Rec'd by:_____ Date: _____
Amount: _____ Check#:_____
Risk Category (I, H, M, L): _____

FOOD ESTABLISHMENT PERMIT RENEWAL APPLICATION

Establishment Name: _____
Establishment Address: _____
City: _____ State_____ Zip Code_____
Phone #:_____ Fax #:_____
Email Address: _____
Additional Email Addresses (Managers, Finance, etc.): _____
_____
Mailing Address (if different from above): _____
Site Contact's Name: _____ Site Contact's E-mail address: _____
Email Address to Which You Would Like Inspection Reports Sent: _____

OWNERSHIP INFORMATION:

Ownership Type: ◯ Individual/Sole Proprietor ◯ LLC ◯ Corporation ◯ Government ◯ Institution
Legal Ownership/Owner Name: _____
Owner Address: _____ City:_____ State: _____ Zip Code: _____
Owner E-Mail_____
Phone #:_____Fax #:_____
Corporate Contact: _____Phone #:_____

ESTABLISHMENT OPERATIONS:

Days and Hours of Operation:

☐Sunday	☐ Monday	☐Tuesday	☐Wednesday	☐ Thursday	☐ Friday	☐ Saturday
_____	_____	_____	_____	_____	_____	_____

Please note any menu changes or attach a current menu to renewal application: _____

If the establishment is open fewer than 12 months out of the year, during what months does the establishment operate?
From: to:

Does the establishment have a frozen dessert (soft serve) machine? ☐ Yes ☐ No
If yes, what is the frozen dessert license number and expiration date? License #: _____ Expiration: _____

What is the average number of meals or patrons served each day? ☐ 1-150 ☐ 151-400 ☐ 401+
Do you serve a highly susceptible population, such as small children or the elderly: ☐Yes ☐No

Billing Information: Billing information should be mailed to: ☐ Establishment Address ☐ Owner Address
☐Other: Name: _____Address: _____ City: _____ State: ____ Zip: _____

I, the undersigned, attest to the accuracy of information provided in this application and understand that any misrepresentation of omission of fact will render this application and any permit issued as invalid. I am familiar with the requirements of the Platte County Missouri Food Code and understand that my food permit may be suspended or revoked by the Platte County Health Department for failure to comply with the provision in the Code. Once approved, I understand the food establishment permit is non-transferrable from one person to another, from one location to another, or from one type of food service operation to another.

_____ _____ _____
Signature of Applicant **Title** **Date**