ANNE ARUNDEL COUNTY
MARYLAND
DEPARTMENT OF HEALTH

Instructions
Mobile Unit Food Service Facility License Application

Mobile Unit's Name: Indicate name of business that will be placed on the outside of the vehicle/cart.

Business Owner Mailing Address and E-mail: Should be legal tax name, if you are incorporated put name of corporation.

Vehicle Storage Address: Indicate where vehicle/cart/trailer will be parked during non-business hours.

Depot Location: Indicate location where food and other supplies are stored, potable water is obtained and where washing is conducted.

Make, Model #, Color, Year: Indicate vehicle(s) manufacturer's name, model (model #s if applicable), color and year of vehicle/cart/trailer.

License Number: Indicate State and license plate number.

Serial Number (VIN): Indicate vehicle identification number located on your vehicle registration card and on dashboard of vehicle.

Special Markings: Any extraneous names or numbers besides mobile unit name outside of vehicle.

Menu: Indicate types of food served on mobile unit.

Refrigeration: Electrical refrigerator/freezer or ice.

Route or Location: Indicate in what area you will be operating or specific location.

Unit Movement: Indicate whether you move unit on a daily basis.

Federal ID#: Indicate number issued to business owner by Internal Revenue Service.

Seasonal Operation: Indicate yes or no. If yes, indicate months of the year you will be operating.

NOTE: Please sign and date application. Below signature line, please print applicant's name, address and phone number.

MAKE CHECKS PAYABLE TO CONTROLLER ANNE ARUNDEL COUNTY.

Send or bring this application, Proof of Workmen's Compensation Insurance (or a Certificate of Eligibility) and application fee to the address located at the top of the application.

PLEASE NOTE: LICENSE EXPIRES ON FEBRUARY 28 OF EACH YEAR.

ANNE ARUNDEL COUNTY
MARYLAND
DEPARTMENT OF HEALTH

FOOD SERVICE FACILITY - LICENSE APPLICATION
HOUSING & FOOD PROTECTION SERVICES
BUREAU OF ENVIRONMENTAL HEALTH
ANNE ARUNDEL COUNTY DEPARTMENT OF HEALTH
3 HARRY S. TRUMAN PARKWAY
ANNAPOLIS, MARYLAND 21401
(410) 222-7364

MOBILE UNIT

(PLEASE PRINT)

MOBILE UNIT'S NAME _____

BUSINESS OWNER _____ **BUSINESS OWNER'S E-MAIL** _____

MAILING ADDRESS _____

PHONE NUMBER _____ **CITY/STATE/ZIP** _____

VEHICLE STORAGE ADDRESS _____

DEPOT LOCATION: _____

MAKE: _____ **MODEL NUMBER:** _____ **COLOR:** _____ **YEAR:** _____

LICENSE NUMBER (STATE): _____ **VIN NUMBER:** _____

SPECIAL MARKINGS (NAME, NUMBER, ETC.): _____

MENU: _____

REFRIGERATION: **( ) YES NO ( )** **IF REFRIGERATED, TYPE: ( ) ICE ( ) MECHANICAL**

ROUTE OR LOCATION: _____

DO YOU MOVE YOUR UNIT ON A DAILY BASIS: YES ( ) NO ( ) IF NO PLEASE EXPLAIN:

_____

SEASONAL OPERATION: YES ( ) NO ( ) IF YES, DATES OF OPERATION _____

ISSUANCE OF THIS LICENSE/PERMIT IS CONDITIONED ON THE APPLICANT'S CONSENT TO INSPECTIONS; THAT SUCH INSPECTIONS WILL FOCUS ON DETERMINING LICENSEE'S/PERMITEE'S COMPLIANCE WITH THE LAWS AND REGULATIONS RELATED TO THE LICENSE/PERMIT; THAT INSPECTIONS WILL BE CONDUCTED AT REASONABLE TIMES UNLESS THE HEALTH OFFICER HAS REASON TO BELIEVE THAT VIOLATIONS ARE OCCURRING THAT CAN ONLY BE DETECTED AT OTHER TIMES; THAT FAILURE TO ALLOW INSPECTIONS MAY RESULT IN SUSPENSION OR REVOCATION OF THE LICENSE/PERMIT, IN ADDITION TO ALL OTHER REMEDIES PERMITTED BY LAW.

APPLICANT SIGNATURE/TITLE _____ **DATE** _____

PRINT NAME & ADDRESS _____ **PHONE** _____

FOR OFFICE USE ONLY

AREA: _____
HACCP PRIORITY: _____
ID# _____
DATE APPROVED _____
INSPECTOR _____

( ) NEW	**$ 395.00**
( ) RENEWAL	**$ 395.00**
( ) HACCP PLAN REVIEW HIGH/MODERATE PRIORITY	**$ 750.00**
( ) RECIPROCITY	**$ 300.00**

(revised 4/17)