

# Parke County Health Department

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Rockville, Indiana 47872  
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**Public Health**  
Prevent. Promote. Protect.

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[parkecounty-in.gov](http://parkecounty-in.gov)

## 2021 Annual Food Permit Application

*(Please Print Clearly)*

This application is for Operating Permits for Food Service Establishment, Markets, and Caterers. **YOU MUST FILL OUT ALL INFORMATION OR THIS APPLICATION WILL NOT BE PROCESSED. A LATE FEE OF \$50.00 WILL BE ADDED IF POSTMARKED AFTER DECEMBER 31<sup>ST</sup>.** We accept Cash, Checks, Money Orders, Discover, Visa, or MasterCard completed application. **IF SENT VIA MAIL, A PRE-STAMPED AND ADDRESSED ENVELOPE MUST BE SENT WITH THE APPLICATION.** If an envelope is not included with application, the permit will available at the Health Department during regular business hours.

Establishment Name: \_\_\_\_\_

Establishment Address: \_\_\_\_\_

Establishment Telephone #: \_\_\_\_\_

Owner's Name: \_\_\_\_\_

Owner's Mailing Address: \_\_\_\_\_

Owner's E-Mail Address: \_\_\_\_\_

Owner's Telephone # \_\_\_\_\_ for Recall Notices/Emergency ONLY

Owner's Fax#: \_\_\_\_\_ for Recall Notices/Emergency ONLY

Operator: \_\_\_\_\_ Directly Responsible for Establishment i.e. Manager

Operator's Mailing Address: \_\_\_\_\_

District Manager (if applicable): \_\_\_\_\_

District Manager Mailing Address: \_\_\_\_\_

District Manager Telephone #: \_\_\_\_\_

Certified Food Handler: \_\_\_\_\_

Food Handler Certificate #: \_\_\_\_\_

(If applicable, you must have a certified food Handler on Staff. **This information *must* also be available at the establishment.**)



**IMPORTANT REMINDER**

**All changes of personnel must be reported to the Parke County Health Department immediately.**

**Hours of Operation**

**Sunday** \_\_\_\_\_

**Monday** \_\_\_\_\_

**Tuesday** \_\_\_\_\_

**Wednesday** \_\_\_\_\_

**Thursday** \_\_\_\_\_

**Friday** \_\_\_\_\_

**Saturday** \_\_\_\_\_

I, \_\_\_\_\_, attest to the accuracy of the information provided in this application. I allow the Parke County Health Department access to the establishment of application and all pertinent records as specified in 410 IAC 7-15.5 and IAC 7-24 in compliance with the Parke County Food Protection Ordinance – 4.

Date of Application: \_\_\_\_\_ Amount Enclosed: \_\_\_\_\_

**Signature of Owner or Manager:** \_\_\_\_\_

# Parke County Health Department

## Credit/Debit Card Payment Authorization Form

The completion and signing of this form authorizes the Parke County Health Department use of the credit/debit card information listed below. The Parke County Health Department also has permission to debit the account for any fees due to applicant.

Please complete fully

I, \_\_\_\_\_ authorize the Parke County Health Department to charge my credit/debit card account in an amount due for licenses, permits, or vital record searches and/or certificates on or after \_\_\_\_\_.

Signature \_\_\_\_\_

I authorize the above named to charge the credit/debit card indicated in this authorization form according to the terms outlined above. This authorization is limited to one use. I certify that I am an authorized user of the aforementioned card. I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Phone: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Email: \_\_\_\_\_

### Office Use Only

Authorization # \_\_\_\_\_ Initials: \_\_\_\_\_ Date: \_\_\_\_\_

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### Please Fill Out Card Information

Account Type (Circle One):    Visa                      MasterCard                      Discover

Account Number: \_\_\_\_\_                      Expiration Date: \_\_\_\_\_

Security Code (3 Digit): \_\_\_\_\_