Fee_____Check#_____I
License #_____

20__
CHESTER BOROUGH
HEALTH DEPARTMENT

APPLICATION FOR ANNUAL FOOD SERVICE ESTABLISHMENT LICENSE

Applicant's Name_____

Applicant's Address_____

Phone #'s: Home_____Business_____Fax_____

Name of Business to be licensed_____

Business Address: Business Mailing Address

_____ _____

_____ _____

_____ _____

Ownership: ☐ Individual ☐ Partnership ☐ Corporation

If partnership or Corporation, please list the names & address of Officers:

_____

_____

Description of food services to be rendered:_____

_____

How many seats are available?_____

Do you have a bathroom for public use?_____

In consideration of such license, I hereby agree at all times to conduct the said premises in conformance with the purposes, intent, and provisions of the Food Handling Establishment Ordinance, the Food and Beverage Vending Machine Ordinance, the Solid Waste Disposal Ordinance, the Grease Trap Ordinances and other ordinances of the Health Department, the amendments and supplements thereto, other ordinances of the municipality and statuary laws of the State of New Jersey relating to the conduct of such business.

NO LICENSE SHALL BE TRANSFERABLE. Licenses may be suspended or revoked by the Health Department upon violation of the purposes, intent and provisions of the Food Handling Establishment Ordinance, the Food and Beverage Vending Machine Ordinance, the Solid Waste Disposal Ordinance, the Grease Trap Ordinance and other ordinances of the Health Department, other ordinances of the municipality and statutory laws of the State of New Jersey relating to the conduct of such business.

_____ _____

Signature of Applicant Date

CHESTER BOROUGH
HEALTH DEPARTMENT

AGREEMENT FOR DAILY/WEEKLY REMOVAL OF GARBAGE AND RECYCLING

Food Establishment Name _____

Address_____

_____

Date of Contract_____

Recyclables are removed by_____

THIS SECTION TO BE COMPLETED BY CONTRACTOR

I, the undersigned, herein certify that I have a contract agreement for the daily collection of removal of all garbage from the above mentioned food service establishment.

Name of Company_____

Address_____

_____

Phone #_____ Fax #_____

Signed_____

50 North Road, Chester NJ 07930 Phone 908-879-3660 x2128 Fax: 908-879-0122

CHESTER BOROUGH
HEALTH DEPARTMENT

MAINTENANCE REQUIREMENTS FOR GREASE TRAPS

Name of food establishment_____

Address_____

_____

How often is trap cleaned?_____

Who cleans the trap?_____

Address_____

_____

Phone #_____

A copy of the least cleaning report or statement will need to accompany this application. If this is a new business, a copy of the receipt of purchase and installation will be needed.

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