

APPLICATION FOR FOOD FACILITY

COMPLETE ONE APPLICATION IN FULL FOR EACH TYPE OF SERVICE IN YOUR FACILITY -PLEASE PRINT WHERE POSSIBLE

The personal information collected relates directly to and is necessary for program operation per Section 26 of the Freedom of Information and Protection of Privacy Act. Information that appears on a licence may be disclosed per Section 22(4)(i) of the Act, as it is not considered an unreasonable invasion of personal privacy.

RETURN FORM TO NEAREST HPES OFFICE: <https://www.islandhealth.ca/our-locations/health-protection-environmental-services-locations>

STATUS	NEW <input type="checkbox"/> New Facility <input type="checkbox"/> New Location <input type="checkbox"/> New Ownership AMENDMENT <input type="checkbox"/> Change to Facility	
FOOD FACILITY	FACILITY NAME _____ FACILITY LOCATION ADDRESS _____ CITY _____ POSTAL CODE _____ TELEPHONE _____ FAX _____ EMAIL _____ MAILING ADDRESS IF DIFFERENT FROM ABOVE _____ SEND INVOICE TO <input type="checkbox"/> SAME AS FACILITY <input type="checkbox"/> SAME AS MAILING OR: _____	
FACILITY'S REGISTERED OWNER(S) OR LEASEE(S)	REGISTERED OWNER/LEASEE NAME _____ <input type="checkbox"/> SOCIETY MAILING ADDRESS _____ <input type="checkbox"/> SOLE PROPRIETOR CITY _____ PROV _____ POSTAL CODE _____ <input type="checkbox"/> PARTNERSHIP TELEPHONE _____ FAX _____ ALTERNATE PHONE _____ <input type="checkbox"/> INCORPORATED EMAIL _____	
FACILITY MANAGER / CONTACT	CONTACT NAME _____ POSITION _____ ADDRESS _____ POSTAL CODE _____ TELEPHONE _____ FAX _____ EMAIL _____	
BUILDING INFORMATION	IF THE FACILITY IS PART OF A MALL, NAME OF MALL _____ BUILDING NAME (IF DIFFERENT FROM FACILITY) _____ ADDRESS _____ CITY _____ POSTAL CODE _____	
OWNER OF BUILDING OR COMPLEX	REGISTERED NAME _____ <input type="checkbox"/> SOCIETY MAILING ADDRESS _____ <input type="checkbox"/> SOLE PROPRIETOR CITY _____ PROV _____ POSTAL CODE _____ <input type="checkbox"/> PARTNERSHIP CONTACT/AGENT NAME _____ POSITION _____ <input type="checkbox"/> INCORPORATED TELEPHONE _____ FAX _____ EMAIL _____	
FACILITY SERVICING	WATER SOURCE <input type="checkbox"/> COMMUNITY (SYSTEM NAME) _____ <input type="checkbox"/> WELL <input type="checkbox"/> OTHER SPECIFY _____ SEWAGE DISPOSAL <input type="checkbox"/> SEWER <input type="checkbox"/> ONSITE SEWAGE DISPOSAL	
OPERATIONAL MONTHS	<input type="checkbox"/> JAN <input type="checkbox"/> FEB <input type="checkbox"/> MAR <input type="checkbox"/> APR <input type="checkbox"/> MAY <input type="checkbox"/> JUN <input type="checkbox"/> JUL <input type="checkbox"/> AUG <input type="checkbox"/> SEP <input type="checkbox"/> OCT <input type="checkbox"/> NOV <input type="checkbox"/> DEC <input type="checkbox"/> ALL YEAR	
	WILL YOUR OPERATION PREPARE FOOD/DRINK ON SITE FOR IMMEDIATE CONSUMPTION?	<input type="checkbox"/> YES <input type="checkbox"/> NO
	WILL YOUR OPERATION PREPARE FOOD OFF SITE?	<input type="checkbox"/> YES IF "YES" – LOCATION _____ <input type="checkbox"/> NO
	WILL YOUR OPERATION PROVIDE SEATING FOR CONSUMPTION OF PREPARED FOOD?	<input type="checkbox"/> YES IF "YES" – TOTAL SEATING CAPACITY _____ <input type="checkbox"/> NO
	WILL YOUR OPERATION BE MOBILE?	<input type="checkbox"/> YES IF "YES" – TYPE <input type="checkbox"/> CART <input type="checkbox"/> VEHICLE <input type="checkbox"/> VESSEL <input type="checkbox"/> NO
	WHAT TYPE OF FOOD PREMISES WILL YOU BE OPERATING?	<input type="checkbox"/> RESTAURANT <input type="checkbox"/> TAKE OUT <input type="checkbox"/> MOBILE <input type="checkbox"/> CONCESSION <input type="checkbox"/> STORE <input type="checkbox"/> FISH PROCESSOR <input type="checkbox"/> LOUNGE/BAR <input type="checkbox"/> CARE FACILITY <input type="checkbox"/> KITCHEN <input type="checkbox"/> CATERER <input type="checkbox"/> OTHER _____ SPECIFY _____
	WILL THE FACILITY BE RENTED OR LEASED TO OTHERS?	<input type="checkbox"/> YES IF "YES" ENSURE THEY HAVE CONTACTED OUR OFFICE FOR NECESSARY APPROVAL <input type="checkbox"/> NO
	WILL YOUR OPERATION CONDUCT BUSINESS MORE THAN 14 DAYS IN A 12 MONTH PERIOD	<input type="checkbox"/> YES <input type="checkbox"/> NO
	WILL YOUR OPERATION SELL TOBACCO PRODUCTS?	<input type="checkbox"/> YES IF "YES" <input type="checkbox"/> VENDING MACHINE <input type="checkbox"/> OVER THE COUNTER <input type="checkbox"/> NO
	WILL YOUR OPERATION PROVIDE AN OUTSIDE SMOKING AREA?	<input type="checkbox"/> YES <input type="checkbox"/> NO
VERIFICATION	APPLICANT SIGNATURE _____ DATE DD / MMM / YYYY <small>I hereby certify that the information set out by me in this application is true and correct to the best of my knowledge and belief. I acknowledge that it is an offence to supply false or inaccurate information on this application.</small> PRINT NAME _____ POSITION _____ PROPOSED OPENING DATE _____ PHONE _____ ADDRESS _____ PLANS INCLUDED <input type="checkbox"/> YES <input type="checkbox"/> NO	
FOR OFFICIAL USE ONLY	DATE	INITIALS
	APPLICATION PACKAGE REC'D	FACILITY TYPE
	PLANS APPROVED BY EHO	FACILITY #
	FACILITY APPROVED BY EHO	AMOUNT PAID
	POSTED TO HEALTHSPACE	METHOD OF PAYMENT
	OPERATING PERMIT SENT	RECEIPT #