



CITY OF EASTON PENNSYLVANIA

Health Bureau Initial Application for Food Service Facility

Chapter 78, Food Establishments of the Rules and Regulation of the City of Easton, Pennsylvania issued under the Act of May 23, 1945, P.L. 926 (Act 369), requires that properly prepared plans and specifications for construction, remodeling or alteration of an Eating & Drinking / Food Establishment must be submitted to and approved by the Health Bureau.

PLEASE COMPLETE AND SUBMIT THE FOLLOWING FORM ALONG WITH THE \$150.00 APPLICATION/INSPECTION FEE.

BUSINESS NAME OF FACILITY: _____

BUSINESS ADDRESS: _____

OWNER'S NAME: _____ PHONE: _____

OWNER'S MAILING ADDRESS: _____

CONTACT PERSON & TITLE: _____

CONTACT'S PHONE: _____

FACILITY INFORMATION: NEW _____ REMODELED _____ CONVERSION _____

TYPE OF SERVICE: TAKE-OUT _____ SIT-DOWN SERVICE _____

PROVIDE A BRIEF DESCRIPTION OF THE PROPOSED FOOD AND BEVERAGE SERVICE AND ATTACH A PROPOSED MENU. **(Please see enclosure labeled "Menu Requirements Consumer Advisory")**

PROJECTED SERVICE CAPACITY/NUMBER OF SEATS: _____
(Attach floor plan – Required. Sample Included)

PROVIDE NUMBER OF ANTICIPATED WORKERS: _____

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HAVE ZONING REQUIREMENTS BEEN MET? YES OR NO

HAVE CODE REQUIREMENTS BEEN MET? YES OR NO
(Electrical, plumbing, building, etc.)

HAVE FIRE DEPARTMENT REQUIREMENTS BEEN MET? YES OR NO

HAVE YOU RECEIVED YOUR BUSINESS LICENSE? YES OR NO
(Issued by the City of Easton)

HAVE YOU REGISTERED YOUR BUSINESS NAME WITH THE STATE? YES OR NO
(Attach Confirmation - Required)

DO YOU HAVE YOUR STATE ISSUED FOOD EMPLOYEE CERTIFICATE? YES OR NO
(Attach Copy - Required)

NAME OF SOLID WASTE COLLECTOR (If known): _____

CONSTRUCTION - ANTICIPATED START DATE: _____

ANTICIPATED COMPLETION DATE: _____

SIGNATURE OF APPLICANT _____ DATE: _____

PLEASE ATTACH ALL REQUIRED DOCUMENTATION AND SPECIFICATIONS AND SUBMIT WITH \$150.00 APPLICATION FEE TO:

City of Easton, Bureau of Health
123 South 3rd Street, 2nd Floor
Easton, PA 18042
610-250-6608 fax 610-250-6607
jklabunde@easton-pa.gov

REMINDER: PLEASE SET-UP A PRELIMINARY INSPECTION OF YOUR NEWLY PROPOSED FACILITY UPON SUBMISSION OF YOUR INITIAL APPLICATION.

FOR OFFICE USE ONLY

Amount Received: _____ ***Date Received:*** _____

Health Official ***Date*** _____