KANKAKEE COUNTY HEALTH DEPARTMENT
DIVISION OF ENVIRONMENTAL HEALTH
2390 W. STATION, KANKAKEE, IL 60901
VOICE: (815) 802-9410 FAX: (815) 802-9411

OFFICE USE ONLY
Amt Rcvd. _____
Cash____ Check #_____
Card Type____App#_____
Date Rcvd.____ Rcvd By____
Appvd By_____Mailed____

FOOD SERVICE FACILITY LICENSE APPLICATION

I/we hereby apply for a license to operate a food service establishment in Kankakee County for the period beginning January 1 and ending December 31, _____.

Name of Establishment _____ Phone ( ) _____

Street Address _____City_____State_____Zip_____

Licensee/Owner _____Home Phone ( ) _____

Corporate Owner _____ Phone ( ) _____

Mailing Address_____City_____State_____Zip_____

Operator/Manager_____Home Phone ( ) _____

Email Address _____ Fax Number _____

Are Certified Food Handler(s) on staff? ___Yes ___No If so, how many? _____

In an emergency, how can we contact you? Work Home Fax Email (Please Circle)

Please check what type of facility you are applying for:

_____	Restaurant	_____	Gas Station (Retail)	_____	Day Care
_____	Caterer	_____	Gas Station (Food Service)	_____	Hospital
_____	Tavern	_____	Mobile Unit	_____	Long Term Care Facility
_____	School/Milk Only	_____	School/Satellite Kitchen	_____	School/Full Kitchen
_____	Grocery (sq. ft. of building _____)	_____	Grocery w/deli (Sq. ft. of building _____)		
_____	Other _____				

Business Hours _____ to _____ Days Closed _____

Annual Fee Schedule: Category I - $350.00 ( ) Category II - $300.00 ( ) Category III - $200.00 ( )
Not for Profit (Must meet guidelines) ( )

I AGREE TO ABIDE BY THE KANKAKEE COUNTY FOOD SANITATION ORDINANCE AND THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH FOOD SERVICE SANITATION CODE BOOK.

Print Name _____ Signature_____Date_____

IF THE FACILITY HAS BEEN CLOSED, IF THE MENU HAS CHANGED, IF THE FACILITY NAME HAS BEEN CHANGED, OR IF THERE HAS BEEN A CHANGE OF OWNERSHIP, PLEASE CONTACT THE OFFICE MMEDIATELY.

PAYMENT INFORMATION
Please return this completed, signed and dated application and stipulated fee in the form of a check ( ), cashier's check ( ) or money order ( ) made payable to the **KANKAKEE COUNTY HEALTH DEPT.** Credit card instructions are below.
When you provide a check as payment, you authorize us to use information from your check to process a one-time electronic Funds Transfer (EFT) or a draft drawn from your account, or to process the payment as a check transaction. When we use information from your check to make an EFT, funds may be withdrawn from your account as soon as the same day we receive your payment and you will not receive your check back from your financial institution. If your payment is returned unpaid, you authorize the collection of your payment plus a return fee of $25.00 by EFT or drafts drawn from your account.

If you would like to pay be credit card, please fill out the following information:
( ) Please charge my credit card for the amount as indicated above per the Annual Fee Schedule
Card Type (Please Circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS
CARD NUMBER:__ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ CVS#: __ __ __EXP. DATE: __ __/__ __

SIGNATURE: _____ DATE: _____