

**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:

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

Business Hours _____ to _____ Days Closed _____

Annual Fee Schedule: Category I - \$400.00 () Category II - \$350.00 () Category III - \$250.00 ()
Not for Profit (Must meet guidelines) ()

I AGREE TO ABIDE BY THE KANKAKEE COUNTY FOOD SANITATION ORDINANCE AND THE ILLINOIS DEPARTMENT OF PUBLIC HEALTH 2017 FDA FOOD 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 IMMEDIATELY.

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:** _____