STANDARD APPLICATION FOR NEW LICENSE OR PERMIT

APPLICATION DATE		
MONTH	DAY	YEAR

FOR OFFICE USE				
CAMIS/RECORD NUMBER		LICENSE/PERMIT		
		TYPE	FEE CLASS/ SUBCLASS	
		H		
EXPIRATION DATE		FEE AMOUNT	DOLLARS	CENTS
MO	DAY	YEAR		

NAME OF LICENSE/PERMIT
(For detailed instructions and information about what is required to apply for this permit, please go to www.nyc.gov/healthpermits)

IMPORTANT: Please type or print legibly in ink using capital letters. Allow spaces between completed words or numbers. Standard abbreviations are permitted. All section must be completed in ink.

SECTION A – NAME, ADDRESS AND CONTACT INFORMATION OF ENTITY TO WHICH LICENSE/PERMIT IS TO BE ISSUED

READ CAREFULLY: *Enter the corporate name and location of business establishment. If not incorporated, enter your name(s) and location of business establishment.*

NAME OF CORPORATION, PARTNERSHIP, PARTNERS OR INDIVIDUAL OWNER *(Last Name First)*	TELEPHONE NUMBER (AREA CODE)
TRADE NAME/Doing Business As (DBA)	FAX NUMBER (AREA CODE)
BUILDING NUMBER / STREET	PREMISES LOCATION (FLOOR, STORE #, BOOTH #)
CITY OR TOWN / STATE / ZIP CODE	E-MAIL ADDRESS (REQUIRED)

DATE OF BIRTH (If applying as an individual)	MONTH	DAY	YEAR	OPTIONAL
				GENDER: ☐ Male ☐ Female

Language Preference for Inspections: If the permit you are applying for requires an inspection by the Department of Health and Mental Hygiene, do you prefer that this inspection be conducted in, or translated to, a language other than English? ___ No ___ Yes
If "yes" that language is ___________________________________.

☐ I agree to receive all official notices from the Department of Health only by **email** at the **email** address provided in this application form. An official notice is any correspondence from the Department of Health that requires a response by a date certain. These include, but are not limited to, permit or license renewal notices; notices of fines or fees owed; collection letters and Dunning Notices, and Notices of Violations.

☐ I would like to receive Department of Health publications, including information about new regulations, newsletters, fact sheets and other educational material, only by **email** at the **email** address provided in this application form.

SECTION B – DATE EXPECTED TO OPEN/START OPERATING	SECTION C – NYS SALES TAX ID#	SOCIAL SECURITY NUMBER (If applying as an individual)	ITIN NUMBER (If no SSN and applying as an individual)
MONTH / DAY / YEAR			

SECTION D – MAILING ADDRESS, IF DIFFERENT FROM PERMITTED/LICENSED ESTABLISHMENT'S ADDRESS (INCLUDE APARTMENT #, PO BOX #)

STREET ADDRESS		
CITY OR TOWN	STATE	ZIP CODE

CITYWIDE LICENSING CENTER – DEPARTMENT OF HEALTH AND MENTAL HYGIENE – 42 BROADWAY, NEW YORK, NY 10004

(continued on next page)

SECTION E – LIST NAMES (LAST, FIRST) OF OWNER – PARTNER – CORPORATE OFFICERS						
1	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET		CITY	STATE	ZIP CODE
2	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET		CITY	STATE	ZIP CODE
3	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET		CITY	STATE	ZIP CODE
4	NAME		PHONE NUMBER	E-MAIL ADDRESS		TITLE
	ADDRESS	STREET		CITY	STATE	ZIP CODE

SECTION F

ALL APPLICANTS (EXCEPT THOSE APPLICANTS FOR A MOBILE FOOD VENDING LICENSE, TATTOO LICENCE OR A HORSE LICENSE) MUST COMPLETE THIS SECTION REQUESTING WORKERS' COMPENSATION AND DISABILITY BENEFITS INSURANCE INFORMATION AND PROVIDE COPIES OF PROOF OF CURRENT INSURANCE IF IT IS REQUIRED.

YOUR APPLICATION FOR A PERMIT WILL NOT BE ACCEPTED IF YOU DO NOT COMPLETE THIS SECTION AND PROVIDE THIS INFORMATION AND PROOF IF YOU ARE REQUIRED TO HAVE THIS INSURANCE.

Please check the appropriate box:

☐ The business described in this application has Workers' Compensation and Disability Benefits Insurance as identified below:

Workers' Compensation Insurance Carrier: ____________ Policy #: ____________ Expiration Date: ____________

Disability Benefits Insurance Carrier: ____________ Policy #: ____________ Expiration Date: ____________

OR

☐ Form CE-200 was submitted to the Worker's Compensation Board stating such coverage is not required for this business and a copy with the New York State-assigned Exemption Certificate Number is attached.

Certificate Number: ____________ Issuance Date: ____________

Form CE-200 attesting to an exemption of this requirement can be found at http://www.wcb.ny.gov

Legal reasons for an applicant to qualify for this exemption are listed on Form CE-200. Please review Form CE-200 to see if your business qualifies for this exemption and is not required to obtain Workers' Compensation and Disability Benefits Insurance.

By signing this application for a permit, I agree that I will comply with provisions of the Health Code and other laws that apply to the permitted activity, and that all the statements made in this application are true and complete. Making a false statement is an offense punishable by fines, imprisonment or both. (NYC Administrative Code § 10-154.)	TITLE	ARE YOU 18 YEARS OF AGE OR OVER?
SIGNATURE OF BUSINESS OWNER, PARTNER, OR CORPORATE OFFICER	TELEPHONE NUMBER	☐ YES ☐ NO

ARE YOU REGISTERED TO VOTE?

If not, you may request a Voter Registration form when you submit your application, or you can access www.nyccfb.info/nyc-votes online.

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