

Grundy County Health Department
1320 Union Street Morris, IL 60450
815-941-3115 lwells@grundyhealth.com

FILL OUT COMPLETELY - PRINT OR TYPE -INCOMPLETE FORMS WILL BE RETURNED WHICH MAY DELAY THE ISSUANCE OF YOUR PERMIT

**required field

PLEASE INDICATE: [] RENEWAL [] SEASONAL [] NEW APPLICATION

DATE OF APPLICATION: _____ original permit be mailed to: [] Establishment or [] Corp/Owner address?

*NAME OF ESTABLISHMENT _____

*ESTABLISHMENT STREET ADDRESS _____ CITY _____

ZIP CODE _____ *PHONE _____ FAX _____

*E-MAIL Establishment _____ EMAIL Owner _____

*CERTIFIED FOOD MANAGER _____ CERTIFICATION NUMBER _____ Exp. date: _____

*CERTIFIED FOOD MANAGER _____ CERTIFICATION NUMBER _____ Exp. date: _____

NAME OF OWNER/CORPORATION _____

Contact name _____ PHONE _____ Email: _____

OWNER'S / CORPORATION'S ADDRESS _____ Phone _____

CITY _____ STATE _____ ZIP _____

*Mailing Name _____

*MAILING ADDRESS _____ CITY _____ STATE _____ ZIP _____

(WHERE CORRESPONDENCE/ INVOICES WILL BE MAILED)

1) For a Restaurant, seating capacity: _____ Retail Store Square Footage _____

2)* Establishment's operating hours/days SUN ___ M ___ T ___ W ___ TH ___ FRI ___ SAT ___

NOTICE IF APPLICATION AND FEES ARE HANDLED THROUGH A CORPORATE OR BUSINESS OFFICE, IT IS THE RESPONSIBILITY OF EACH ESTABLISHMENT TO FORWARD INFORMATION IF ALTERNATE MAILING ADDRESS NOT AVAILABLE

MAKE CHECK OR MONEY ORDER PAYABLE TO: GRUNDY COUNTY HEALTH DEPARTMENT

DO NOT SEND CASH PAYMENTS IN MAIL -

PERMIT FEE/RENEWAL APPLICATION DUE BY JANUARY 31 or 25% LATE FEE WILL BE APPLIED

(FOR OFFICE USE ONLY)

RECEIPT# _____ AMOUNT PAID: _____ DATE PAID: _____

PERMIT # _____ CHECK #: _____ CASH: _____ CC AUTHORIZATION #: _____

