

**HEALTH FACILITY APPLICATION FOR PERMIT TO  
OPERATE/CONSTRUCT FOOD/DRINK/RETAIL/ SALES  
ESTABLISHMENT**

**FOR OFFICE USE ONLY**

Permit No. \_\_\_\_\_  
Date Issued \_\_\_\_\_  
Expiration Date \_\_\_\_\_

**PAYMENT INFORMATION:** *(Completed by EHS)*

Permit Fee \$ \_\_\_\_\_ Date Paid \_\_\_\_\_ Check No. \_\_\_\_\_ Receipt No. \_\_\_\_\_  
Plan Review Fee \$ \_\_\_\_\_ Date Paid \_\_\_\_\_ Check No. \_\_\_\_\_ Receipt No. \_\_\_\_\_  
Plan(s) Received \_\_\_\_\_ Plan Review No. \_\_\_\_\_  
Conditions of Permit \_\_\_\_\_

**ENVIRONMENTALIST (EHS) APPROVAL FOR PERMIT:**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**CHANGE:** *(Completed by Applicant)*

Name of Establishment: \_\_\_\_\_

Address of Establishment: \_\_\_\_\_

\_\_\_\_\_

Owner: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_

Operator in Charge *(Name on Permit)*: \_\_\_\_\_

Previous Name of Establishment, Ownership or Operator: \_\_\_\_\_

**ESTABLISHMENT INFORMATION:** *(Completed by Applicant)*

New \_\_\_\_\_ Remodeled \_\_\_\_\_ Ownership Change \_\_\_\_\_

Service Capacity: No. of Seats/Clients/Residents \_\_\_\_\_ Square Feet \_\_\_\_\_

**MAIN FACILITY/SUPPORT  
FACILITY (02)**

Restaurant \_\_\_\_\_

Buffet/Cafeteria \_\_\_\_\_

Snack Bar/Deli \_\_\_\_\_

Concession \_\_\_\_\_

Main/Banquet/Kitchen \_\_\_\_\_

Caterer \_\_\_\_\_

Service Bar *(No Seats)* \_\_\_\_\_

Portable Food Unit *(Not Fixed)* \_\_\_\_\_

Other *(Specify)* \_\_\_\_\_

**TEMPORARY PERMITS**

*(14 Days or Less)*

Type of Operation \_\_\_\_\_

Opening Date \_\_\_\_\_

Closing Date \_\_\_\_\_

**ADDITIONAL PERMIT DESCRIPTION/INFORMATION:**

You are responsible for contacting the Environmental Health Specialist whenever there is a change of operator/ownership or remodeling your facility. Change in menu or food for sale that necessitates a change of equipment or additional square footage/seating must be approved prior to beginning the changes in your establishment. Plans must be submitted for all extensive remodeling and approved before construction begins.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

**\*\*All fee/payments must be made payable to the Nevada State Treasurer. Please mail application(s) and fee to:**

**DIVISION PUBLIC AND BEHAVIORAL HEALTH  
BUREAU OF HEALTH CARE QUALITY AND COMPLIANCE  
ATTN: FOOD PERMITS  
727 FAIRVIEW DRIVE, STE. E  
CARSON CITY, NV 89701**