MOBILE UNIT
PLAN REVIEW APPLICATION

Division of Environmental Health
Food Protection Program
445 Winn Way, Suite 320
Decatur, GA 30030
Phone: (404) 508-7900 Fax: (404) 508-7979
www.dekalbhealth.net

PLEASE PRINT IN CAPITAL LETTERS.

Person Requesting Plan Review

Name: ____

Phone: ( ) ____________________ **Cell Phone:** ( ) ____________________

Facility Requiring Plan Review

Name: ____

Address: ______________________________ **City:** ____________________

<u>NOTICE:</u> A PERMIT APPLICATION AND ADDENDUM FOR THE FACILITY MUST BE COMPLETED, SIGNED AND RETURNED TO THE DIVISION OF ENVIRONMENTAL HEALTH <u>BEFORE</u> THE PLAN REVIEW PROCESS BEGINS.

Plan Submittal Information:

One set of plans is required for a review and will be retained by the Division of Environmental Health.

Please enclose the following documents:

- ❑ **Copy of the Base of Operation Permit (*only applies to base of operation in counties other than DeKalb*)**
- ❑ **Completed food service permit applications and verification of residency form**
- ❑ **Proposed Menu (including seasonal)**
- ❑ **Proposed Mobile Unit Route Schedule**
- ❑ **Manufacturer Specification sheets for each piece of equipment shown on the plan**
- ❑ **Plan (drawn to scale) of mobile unit showing location of equipment, plumbing (fresh and gray water tank capacities; water pump), generator and mechanical ventilation, BBQ pit enclosures**
- ❑ **Physical facilities cosmetic finish schedule**
- ❑ **Water supply (include hot water heater specifications manufacture name and model number)**
- ❑ **Complies with all other provisions of laws that apply to the location, construction and maintenance of food service establishments and the safety of persons therein**

Please NOTE: A fee will be assessed for the plan review and a separate permit fee prior to issuing permit. The plan review fee will be calculated based on submitted plans, applications, and menu. Payment is due at time of submission at DeKalb County Board of Health Environmental Health Office.

FOOD SERVICE PERMIT APPLICATION FORM

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This form must be completed for all new and change of ownership facilities and for any changes to facility information. **If the information on this application or application addendum changes this department is to be notified. Picture identification is required to process application (i.e. driver's license, passport, etc.)** (PRINT IN CAPITAL LETTERS)

Facility Name: (as it will show on permit)		Phone: ( ) ____________ Fax : ( ) ____________
Facility Address: Suite #:	City: ____________ Zip Code: ____________	E-mail:____________ Website: ____________
Anticipated Opening Date:	Is this food establishment located within a hotel, bar or office space? (If yes, provide name)	

Food Service Operation(s) Classification: ☐Restaurant ☐Mobile Unit ☐ Mobile Base of Operation ☐Caterer ☐Delivery
☐Drive-Through ☐ Bar/Lounge ☐Institution (specify)______
☐ Extended Food Service ☐ Incubator A **(VARIANCE REQUIRED)** ☐ Incubator B **(VARIANCE REQUIRED)**

OWNERSHIP INFORMATION

Ownership Legal Type: ☐ Sole Owner ☐ Partnership ☐ LLC **(Provide State Registration)**
☐ Corporation **(Provide State Registration)** ☐ Franchise

Name of Ownership:		Owner's Home Phone: ( )____________ Owner's Cell Phone: ( )____________
Owner's Address:	City: ____________ State: ____________ Zip Code:	E-mail: ____________ Fax Number: ( )____________

BILLING INFORMATION (for INVOICES) ***same as facility*** ☐ **or:**

Bill to Name: Bill to Address:	City:____________ State: ____________ Zip Code: ____________	Phone: ( )____________ E-mail: ____________ Fax Number: ( )____________

AUTHORIZED AGENT INFORMATION: Authorized Agent (person affiliated with establishment after opening) for a corporation may sign this document in lieu of owner. No other agent's signature will be accepted.

Agent's Name:	Home Phone: ( )____________ Cell Phone: ( )____________
Address	City:____________ Zip Code:____________

CERTIFIED FOOD SAFETY MANAGER (CFSM) INFORMATION

CFSM Name:	Certificate Expiration Date: **** Please provide a copy**	Phone: ( )____________ Cell Phone: ( )____________

The undersigned hereby applies for a permit to operate a Food Service Establishment pursuant to the OCGA 26-2-371-373 and hereby certifies that the undersigned has received a copy of the Rules and Regulations for Food Service, Chapter 290-5-14, Georgia Department of Human Resources. The undersigned hereby attests to the accuracy of the information provided in this application, and affirms that the undersigned will comply with this chapter, and allow the Health Authority access to the establishment.
IT IS UNLAWFUL TO PROVIDE FALSE INFORMATION ON THIS DOCUMENT.

Signature:	Date:
Signature:	Date:
Signature:	Date:

FEES ARE NOT TRANSFERABLE OR REFUNDABLE

Office Use Only

Establishment #: ____________ Inspector ID #:____________	Menu type: ☐ No Cook ☐ Cook-Serve ☐ Complex a) ☐ Facility Name change: Old name:____________ b) ☐ Billing Address change ☐ Owner Address change c) ☐ Corporation name change d) ☐ Facility closed (voluntary) Effective Date ____________

PARTNERSHIP INFORMATION		
Partner's Name:		Partner's Home Phone: ( )____________ Partner's Cell Phone: ( ) ______________
Partner's Address:	City: ____________________ Zip Code: ________________	E-mail: _______________________ Fax Number: ( )______________
Business Address:	City: ____________________ Zip Code: _______________	Business Phone Number: ( ) _________________________

Partner's Name:		Partner's Home Phone: ( )____________ Partner's Cell Phone: ( ) ______________
Partner's Address:	City: ____________________ Zip Code: ________________	E-mail: _______________________ Fax Number: ( )______________
Business Address:	City: ____________________ Zip Code: _______________	Business Phone Number: ( ) _________________________

Partner's Name:		Partner's Home Phone: ( )____________ Partner's Cell Phone: ( ) ______________
Partner's Address:	City: ____________________ Zip Code: ________________	E-mail: _______________________ Fax Number: ( )______________
Business Address:	City: ____________________ Zip Code: _______________	Business Phone Number: ( ) _________________________

Partner's Name:		Partner's Home Phone: ( )____________ Partner's Cell Phone: ( ) ______________
Partner's Address:	City: ____________________ Zip Code: ________________	E-mail: _______________________ Fax Number: ( )______________
Business Address:	City: ____________________ Zip Code: _______________	Business Phone Number: ( ) _________________________

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ADDENDUM TO
APPLICATION FOR FOOD SERVICE PERMIT

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The following information is REQUIRED. Please return this completed form with the FOOD SERVICE PERMIT APPLICATION.

Name of Establishment: ____________________

Name of Base of Operation: ____________________
(*Provide copy of DPH Base Permit if located outside DeKalb County)*

Establishment Address: ____________________

Number of Seats: ________ **Total Square Footage of mobile unit:**________

TOTAL Number of Managers:______ **Food Handlers:**______

Estimated/Projected Number of Meals Served Weekly (approximate number):
Breakfast:______ **Lunch:**______ **Dinner:**________ **Cater:**______

Total number of Managers with supervisory responsibility certified in Food Safety (i.e. ServSafe Certified, HACCP Certfied,etc.) Please mail copies of certificates with application: ________

Type of Service [check all that apply]:

☐ **Mobile Vending** ☐ **Catering** ☐**Single-use utensils**

Days and Hours of Operation

Day	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
OPENING TIME:							
CLOSING TIME:							

Signature: ____________________ **Date:** ____________

Print Name:____________________ **Owner** ☐ **Agent** ☐

NOTICE

PLAN REVIEW INFORMATION: IN ACCORDANCE WITH DPH CHAPTER 511-6-1-.02(4), THIS INFORMATION WILL BE UTILIZED BY THE LOCAL HEALTH AUTHORITY IN ITS REVIEW AND APPROVAL PROCESS OF SUBMITTED PLANS AND SPECIFICATIONS FOR PROPOSED NEW CONSTRUCTION, OR REMODELING AND CONVERSION OF EXISTING BUILDINGS FOR PROPOSED FOOD SERVICE ESTABLISHMENTS. ADDITIONALLY, THIS INFORMATION WILL BE UTILIZED BY THE LOCAL HEALTH AUTHORITY TO ACCESS THE LEVEL OF COMPLIANCE STATUS OF EXISTING FOOD SERVICE ESTABLISHMENTS DURING THE OCCURRENCE OF A CHANGE IN PERMIT HOLDER.

AS PER DPH CHAPTER 511-6-1-.02(1)(c), IN ORDER TO QUALIFY FOR A PERMIT TO OPERATE A FOOD SERVICE ESTABLISHMENT, THE PERMIT APPLICANT MUST 1) BE AN OWNER OF THE PROPOSED FOOD SERVICE ESTABLISHMENT (OR AN OFFICER OF THE LEGAL OWNERSHIP), 2) AGREE TO ALLOW THE HEALTH AUTHORITY ACCESS TO THE FOOD SERVICE ESTABLISHMENT, 3) PROVIDE ALL REQUIRED INFORMATION REQUESTED BY THE HEALTH AUTHORITY AND PAY ALL APPLICABLE FEES; AND 4) PROVIDE EVIDENCE OF SATISFACTORY COMPLIANCE WITH THE PROVISIONS OF THE CHAPTER AND ALL OTHER PROVISIONS OF LAWS THAT APPLY TO THE LOCATION, CONSTRUCTION AND MAINTENANCEE OF FOOD SERVICE ESTABLISHMENTS AND THE SAFETY OF PERSONS THEREIN.

AT THE HEALTH AUTHORITY'S INITIAL INSPECTION OF THE COMPLETED FOOD SERVICE ESTABLISHMENT AND PRIOR TO THE ISSUANCE OF A PERMIT BY DEMONSTRATING SATISFACTORILY COMPLIANCE WITH THE PROVISION OF DPH CHAPTER 511-6-1; AND PROVIDING WRITTEN DOCUMENTATION INDICATING SATISFACTORY COMPLIANCE WITH ALL OTHER PROVISIONS OF LAWS THAT APPLY TO THE FOOD ESTABLISHMENT'S LOCATION, CONSTRUCTION AND MAINTENANCE, AND THE SAFETY OF PERSONS THEREIN.

INSTRUCTIONS: COMPLETE THE FOLLOWING APPLICATION DOCUMENT IN DUPLICATE AND FORWARD THE ORIGINAL COMPLETED DOCUMENT TO DEKALB COUNTY BOARD OF HEALTH.

DeKalb County EH - MOBILE UNIT APPLICATION: Supplemental Questionnaire

1. **Mobile Unit Name**________________________________ **Mobile Unit License Plate#**______________________
   Mobile VIN Number_________________________
2. **Handsink Dimensions**: Length=_____" Width=_____" Depth=_____" Location_________________________
3. **Warewashing Sink:** #Compartments (3 or 4?) ______ Total Sink Length (not incl. drain boards) =_______"
   Width=______" Depth=______" Location__________________________________
4. **Cold Holding Equipment:** (**Minimum of 2 Required** except in rare cases)
   1. __________________________________
   2. __________________________________
   3. __________________________________
   4. __________________________________
5. **Hot Holding Equipment**:
   1. __________________________________
   2. __________________________________
   3. __________________________________
6. **Hot Water Heater:** Location?___________________________________
   a. Model #___________________________________
      How many gallons? __________ (Minimum of 10 gallons; an urn may be added to meet requirements)
   b. Tankless/On Demand? Y/N?__________
7. **Fresh Water Supply Tank**:
   a. How many gallons? __________
   b. Location?______________________________ Location of water inlet?____________________________
8. **Waste Water Holding Tank**:
   a. How many gallons? __________
   b. Location?______________________________ Location of water outlet?__________________________
9. **How Water Supply is Maintained:** Pressurized?____ Or Pump?____ Pump Model#_____________________
10. **Water Supply Hose**: Color?_________ Material?___________________________ Food Grade Y/N__________
11. **Serving Window(s):** (that will remain open during operation) **How is it equipped to Control Pests**?
    Specify Control Method: (i.e. Air Curtains/Fly Fans, Sliding Screens, etc)_______________________________
12. **Finishes/Materials**: (i.e. Aluminum, FRP, Stainless Steel, etc) :

    Floor____________________________ Walls_________________________ Ceilings___________________________

DeKalb County Environmental Health

MOBILE UNITS PROPOSED GENERATOR SPECIFICATIONS

Equipment/Fixtures	**Power in Watts**
Lights	
Hood vent	
Air curtain	
Water Heater	
Water Pump	
Refrigeration	
Prep Top Cooler	
Reach-in cooler	
Freezer	
Other:	
Hot Holding	
Baine Marie	
Steam Table	
Warming cabinet	
Other:	
Cooking	
Fryer	
Grill	
Other: Swan Block Shaved Ice Mach.	
Other:	
Other:	
Total	
Proposed Generator Power	

Georgia Food Service Mobile Unit Location listing

Name of Mobile unit:___________________________________**License Number:** _____________________________

Name of Base of Operation:______________________________Name of Permit Holder: ________________________

Specific LOCATION	TIME of Day	Day of WEEK (please circle applicable days)	Specific location of TOILET ROOMS available to the mobile unit
		M T W Th F Sa Su	
		M T W Th F Sa Su	
		M T W Th F Sa Su	
		M T W Th F Sa Su	
		M T W Th F Sa Su	

Note: The specific location may be a physical address or intersection of road with landmarks by which the mobile can be located. A change in the locations listed must be submitted to the local Health Authority at least 7 days prior to changing the location. Prior to a change in location, ensure authorization has been granted from the local City/County government office (e.g. Zoning).

I attest that the aforementioned mobile unit will operate at the above listed locations as submitted to the Health Authority this _____ day of_____20____.

Name:____________________________________ Title: ____

Sign: ____________________________________

Note: This form should only be completed by the owner or corporation member, not the architect or expeditor.

GEORGIA DEPARTMENT OF PUBLIC HEALTH

Verification of Lawful U.S. Residency for License Application

O.C.G.A. Section 50-36-1(e)(2)

As part of my application for licensure from the Georgia Department of Public Health, I hereby swear, under oath, that I am:

[*Check one of the following*]

(1) _____ A citizen of the United States;

(2) _____ A legal permanent resident of the United States;

or

(3) _____ A qualified alien or non-immigrant under the Federal Immigration and Nationality Act. The alien number assigned to me by the United States Department of Homeland Security or other federal immigration agency is Alien Number__________________.

I also swear that I am eighteen years of age or older, and that I have provided at least one secure and verifiable identity document with this affidavit, as required by O.C.G.A. Section 50-36-1(e)(1). The secure and verifiable document is my______________________________

____.

The original "secure and verifiable document" was shown to the notary public, and a true copy of the document is attached to my application with this affidavit.

In making these representations, I understand that any person who knowingly and willfully makes a false statement in an affidavit on any matter within the jurisdiction of state government shall be guilty of a violation of O.C.G.A. Section 16-10-20 and face criminal penalties authorized by that statute.

Subscribed and sworn before me this _____ day of____________________, 20_____.

____

Signature of Applicant

____

Printed Name Of Applicant

____

Notary Public

My Commission Expires ______________