SOUTH PLAINFIELD HEALTH DEPARTMENT

2480 Plainfield Avenue, South Plainfield, NJ 07080

REINSPECTION APPLICATION

ESTABLISHMENT *INFORMATION:*

Name: _____ Phone #: _____

Address:: _____ Fax #: _____

OWNER *INFORMATION:*

Name: _____ Phone # _____

Address: _____

MANDATORY EMAIL ADDRESS:_____

EMERGENCY CONTACT PERSON:

NAME: _____ TITLE: _____

EMERGENCY/AFTER HOURS PHONE NUMBER: _____

NON-REFUNDABLE APPLICATION FEE

REINSPECTION FEES	AMOUNT	
1st Reinspection by Health Officer	$ 75.00	_____
2nd Reinspection by Health Officer	$100.00	_____
3rd Reinspection by Health Officer	$125.00	_____
	TOTAL AMOUNT:	_____

NOTE: **Application is to be completed and returned with a check payable to the "*South Plainfield Health Department*" by March 31st otherwise a $50.00 PER MONTH late fee will be incurred.**

FOR OFFICE USE ONLY.

LICENSE # _____ DATE ISSUED: _____

METHOD OF PAYMENT: CASH $_____ CHECK $_____ CHECK NUMBER _____