

**SOUTH PLAINFIELD HEALTH DEPARTMENT**  
2480 Plainfield Avenue, South Plainfield, NJ 07080

**WHOLESALE FOOD ESTABLISHMENT APPLICATION**

ESTABLISHMENT NAME: \_\_\_\_\_

ESTABLISHMENT ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ FAX: \_\_\_\_\_

OWNER NAME: \_\_\_\_\_

OWNER ADDRESS: \_\_\_\_\_

MANDATORY EMAIL: \_\_\_\_\_

***CONTACT PERSON:***

NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_

EMERGENCY/AFTER HOURS PHONE NUMBER: \_\_\_\_\_

**NON-REFUNDABLE APPLICATION FEE**

ESTABLISHMENT TYPE

MANUFACTURED \$175.00 \_\_\_\_\_

NON-MANUFACTURED \$100.00 \_\_\_\_\_

LATE PENALTY \$50.00 PER MONTH AFTER MARCH 31ST \_\_\_\_\_

***TOTAL AMOUNT:*** \_\_\_\_\_

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

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**FOR OFFICE USE ONLY.**

LICENSE # \_\_\_\_\_ DATE ISSUED: \_\_\_\_\_

METHOD OF PAYMENT: CASH \$ \_\_\_\_\_ CHECK \$ \_\_\_\_\_ CHECK NUMBER \_\_\_\_\_