



Stephanie Mendelsohn  
Health Director

Sharon McNellis-Kissel  
Health Officer

## The Township of Ewing Board of Health

BERT H. STEINMANN, MAYOR

AARON T. WATSON, BUSINESS ADMINISTRATOR

### Public Recreational Bathing Facility Permit Application

Name of Establishment: \_\_\_\_\_  
Address of Establishment: \_\_\_\_\_ Block: \_\_\_\_\_ Lot: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Name of Owner: \_\_\_\_\_  
Address of Owner: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Name of Contact: \_\_\_\_\_ Title: \_\_\_\_\_  
Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Fax: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Name of Pool Management Company: \_\_\_\_\_  
Address of Pool Management Company: \_\_\_\_\_  
Phone Number: (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Licensed Certified Pool Operator - First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
Phone Number (\_\_\_\_)\_\_\_\_-\_\_\_\_\_ Email: \_\_\_\_\_

Opening Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Closing Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Hours of Operation: \_\_\_\_\_

Annual Pool License ----- \$350.00   
(Annual licenses run from June 1<sup>st</sup> to May 31<sup>st</sup>)

Seasonal Pool License ----- \$250.00

\*Please be advised that for all bathing facilities MUST also have and approved annual Electrical Inspection from the Ewing Township Code Enforcement Office prior to scheduling an inspection with the Health Department.

Satisfactory Electrical Inspection Received by Health Department

**I CERTIFY TO THE BEST OF MY KNOWLEDGE ALL FACTS AND DATA SUPPLIED ARE TRUE AND CORRECT.**

Applicants Name (Print): \_\_\_\_\_ Title: \_\_\_\_\_  
Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**OFFICIAL USE ONLY**

Received by: \_\_\_\_\_ Date: \_\_\_\_\_  
Fee Collected: \_\_\_\_\_ Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Credit Card: \_\_\_\_\_  
Health Officer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(PAYMENT SHALL BE MADE TO THE TOWNSHIP OF EWING)