



Stephanie Mendelsohn  
Health Director

W. Allen Lee  
Health Officer

## The Township of Ewing Board of Health

BERT H. STEINMANN, MAYOR

AARON T. WATSON, BUSINESS ADMINISTRATOR

### RETAIL FOOD ESTABLISHMENT PLAN REVIEW 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: \_\_\_\_\_

#### Proposed Work

New Construction \_\_\_\_\_ Renovation \_\_\_\_\_ Repair \_\_\_\_\_

#### Size of Establishment

ZERO to 1,000 square feet -----	\$120.00	<input type="checkbox"/>
From 1,001 to 5,000 square feet -----	\$150.00	<input type="checkbox"/>
Over 5,001 square feet -----	\$250.00	<input type="checkbox"/>
Live Animal Processing Facility -----	\$50.00	<input type="checkbox"/>

\*Please be advised that for all businesses requiring a Retail Food Establishment Plan Review, the applicant MUST also have approval from the Code Enforcement Office and/or appropriate Zoning Official.

Application Received by Health Department

Fee Collected by Health Department

1 Set of Signed Architectural Drawings Received by Health Department

Equipment Specification Sheets Received by Health Department

**The undersigned applicant agrees to operate aforementioned food handling establishment in accordance with the provision of N.J.A.C 8:24 "Sanitation in Retail Food Establishment and Food and Beverage Vending Machines", the governing Code for the State of New Jersey and any local Ordinances.**

#### 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)