Township of Ewing
Health Department
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Health Officer

# The Township of Ewing Board of Health

BERT H. STEINMANN, MAYOR AARON T. WATSON, BUSINESS ADMINISTRATOR

## MOBILE FOOD TRUCK/TEMPORARY MOBILE EVENT APPLICATION _____ (Yr.)

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: _____

Event: _____
Event Location: _____
Event Date(s): _____/____/_____ - _____/____/_____Hours: _____
Event Sponsor/Coordinator Name: Last: _____ First: _____
Sponsor/Coordinator Email: _____ Mobile Phone: (___) ___-_____

If Mobile Vehicle:
License Plate Number: _____ State: _____
Vehicle Insurance Information: _____
Vehicle Registration Information: _____

**Menu:**

| DETAILED MENU ITEMS | HOT / COLD / UNPREPPED | EQUIPMENT USED TO PREPARE | EQUIPMENT USED TO STORE | POTABLE WATER |
|---|---|---|---|---|
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*Please note, a food safety manager level certification must be submitted for any risk type 3 establishments. This includes any establishment that has an extensive menu which requires the handling of raw ingredients; and is involved in the complex preparation of menu items that includes the cooking, cooling, and reheating of at least three or more potentially hazardous foods.

## Commissary Information:

1.Do you operate from a commissary on a daily basis? ☐ YES ☐ NO
If no, explain: _____

2. Do you report back to the commissary at the end of the day for all cleaning, servicing operations and waste disposal? ☐ YES ☐ NO

If no, explain: _____

3. Is this commissary inspected by the Ewing Township Health Department? ☐ YES ☐ NO

*4. If no, please provide a copy of a recent inspection report for the commissary.*

Name of regulatory agency that inspects the commissary:
_____

Business Name or Commissary Owners Name: _____

Street: _____

Phone: _____

City: _____

State: _____ Zip: _____

*The above Commissary is used for the following:*

☐ Food ☐ Water ☐ Supplies

☐ Cleaning of equipment/utensils

☐ Storage of vendor unit

☐ Waste disposal

☐ Repairs of vendor unit

*Note: COPY OF COMMISSARY AND/OR INSPECTION REPORTS MUST BE AVAILABLE FOR HEALTH DEPARTMENT REVIEW.*

***Signature of Commissary Owner/Operator*: _____ Date: _____**

Annual Mobile Truck Fee: ----------$150.00 ☐
Temporary Event Fee: ----------$75.00 ☐

**The undersigned applicant agrees to operate the 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 Check: _____ Credit Card: _____
Collected: _____ Cash: _____ Date: _____
Health Officer's Signature: (PAYMENT SHALL BE MADE TO THE TOWNSHIP OF EWING)
_____