



Gabriella Hogan  
 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

\*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 Collected: \_\_\_\_\_ Cash: \_\_\_\_\_ Check: \_\_\_\_\_ Credit Card: \_\_\_\_\_  
 Health Officer's Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (PAYMENT SHALL BE MADE TO THE TOWNSHIP OF EWING)