island health
Health Protection & Environmental Services

APPLICATION FOR FOOD FACILITY

COMPLETE ONE APPLICATION ***IN FULL*** FOR ***EACH TYPE OF SERVICE*** IN YOUR FACILITY

The personal information collected relates directly to and is necessary for program operation per Section 26 of the Freedom of Information and Protection of Privacy Act. Information that appears on a licence may be disclosed per Section 22(4)(i) of the Act, as it is not considered an unreasonable invasion of personal privacy. If you have any questions about the collection and use of this information, contact the Vancouver Island Health Authority Information & Privacy Office at (250) 370-8043.

(RETURN FORM TO NEAREST HPES OFFICE) PLEASE PRINT WHERE POSSIBLE

http://www.viha.ca/mho/contacts/hpes.htm

STATUS

NEW ☐ New Facility ☐ New Location ☐ New Ownership **AMENDMENT** ■ Change to Facility

FOOD FACILITY

FACILITY NAME

FACILITY LOCATION ADDRESS

CITY POSTAL CODE

TELEPHONE FAX EMAIL

MAILING ADDRESS IF DIFFERENT FROM ABOVE

SEND INVOICE TO ☐ SAME AS FACILITY ☐ SAME AS MAILING OR:

FACILITY'S REGISTERED ☐ OWNER(S) **OR** ☐ LEASEE(S)

REGISTERED **OWNER/LEASEE** NAME

MAILING ADDRESS

CITY PROV POSTAL CODE

TELEPHONE FAX ALTERNATE PHONE

EMAIL

☐ SOCIETY ☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ INCORPORATED

FACILITY MANAGER / CONTACT

CONTACT NAME POSITION

ADDRESS POSTAL CODE

TELEPHONE FAX EMAIL

BUILDING INFORMATION

IF THE FACILITY IS PART OF A MALL, NAME OF MALL

BUILDING NAME (IF DIFFERENT FROM FACILITY)

ADDRESS CITY POSTAL CODE

OWNER OF BUILDING OR COMPLEX

REGISTERED NAME

MAILING ADDRESS

CITY PROV POSTAL CODE

CONTACT/AGENT NAME POSITION

TELEPHONE FAX EMAIL

☐ SOCIETY ☐ SOLE PROPRIETOR ☐ PARTNERSHIP ☐ INCORPORATED

FACILITY SERVICING

WATER SOURCE ☐ COMMUNITY (SYSTEM NAME) ☐ WELL ☐ OTHER SPECIFY

SEWAGE DISPOSAL ☐ SEWER ☐ ONSITE SEWAGE DISPOSAL

OPERATIONAL MONTHS

☐ JAN ☐ FEB ☐ MAR ☐ APR ☐ MAY ☐ JUN ☐ JUL ☐ AUG ☐ SEP ☐ OCT ☐ NOV ☐ DEC ☐ ALL YEAR

WILL YOUR OPERATION PREPARE FOOD/DRINK ON SITE FOR IMMEDIATE CONSUMPTION?	☐ YES	☐ NO
WILL YOUR OPERATION PREPARE FOOD OFF SITE?	☐ YES IF "YES" – LOCATION	☐ NO
WILL YOUR OPERATION PROVIDE SEATING FOR CONSUMPTION OF PREPARED FOOD?	☐ YES IF "YES" – TOTAL SEATING CAPACITY	☐ NO
WILL YOUR OPERATION BE MOBILE?	☐ YES IF "YES" – TYPE ☐ CART ☐ VEHICLE ☐ VESSEL	☐ NO
WHAT TYPE OF FOOD PREMISES WILL YOU BE OPERATING?	☐ RESTAURANT ☐ TAKE OUT ☐ MOBILE ☐ CONCESSION ☐ STORE ☐ FISH PROCESSOR ☐ LOUNGE/BAR ☐ CARE FACILITY ☐ KITCHEN ☐ OTHER SPECIFY	
WILL THE FACILITY BE RENTED OR LEASED TO OTHERS?	☐ YES IF "YES" ENSURE THEY HAVE CONTACTED OUR OFFICE FOR NECESSARY APPROVAL	☐ NO
WILL YOUR OPERATION CONDUCT BUSINESS MORE THAN 14 DAYS IN A 12 MONTH PERIOD	☐ YES	☐ NO
WILL YOUR OPERATION SELL TOBACCO PRODUCTS?	☐ YES IF "YES" ☐ VENDING MACHINE ☐ OVER THE COUNTER	☐ NO
WILL YOUR OPERATION PROVIDE AN OUTSIDE SMOKING AREA?	☐ YES	☐ NO

VERIFICATION

APPLICANT SIGNATURE DATE DD / MMM / YYYY

I hereby certify that the information set out by me in this application is true and correct to the best of my knowledge and belief.
I acknowledge that it is an offence to supply false or inaccurate information on this application.

PROPOSED OPENING DATE

PRINT NAME POSITION

PHONE ADDRESS

PLANS INCLUDED ☐ YES ☐ NO

FOR OFFICIAL USE ONLY

	DATE	INITIALS		
APPLICATION PACKAGE REC'D			FACILITY TYPE	
PLANS APPROVED BY EHO			FACILITY #	
FACILITY APPROVED BY EHO			AMOUNT PAID	
POSTED TO HEALTHSPACE			METHOD OF PAYMENT	
OPERATING PERMIT SENT			RECEIPT #	