



Health Officer: Danielle Weber, MS, RN

APPLICATION FOR PERMIT TO OPERATE A CAMP

Application is hereby made to operate a campground facility in accordance with COMAR 10.16.03 Regulations Governing Camps. Please submit this application with all associated fees and the attached Workers' Compensation form.

Fee: \$200

Late Fee (<60 days): \$100

Late Fee (>60 Days): \$200

| | | |
|--|--|---|
| Facility Name: | Facility Phone: | |
| | Facility Email: | |
| Facility Address: | | |
| Mailing Address: | | |
| Contact Person: | Contact Phone: | |
| | Contact Email: | |
| Owner: | Owner Phone: | |
| | Owner Email: | |
| Federal Employer ID Number (EIN) (Required): | Water Supply: <input type="radio"/> Public <input type="radio"/> Private | Sewage Disposal: <input type="radio"/> Public <input type="radio"/> Private |
| Operation Is: <input type="radio"/> Permanent <input type="radio"/> Seasonal (from _____ to _____) | Total Number of Campsites: _____ | |
| Average Number of Visitors Per Day: _____ | Type of Campsites: Hook-Up: _____ Primitive/Tent: _____ Cabin/Building: _____ | |
| Estimated Number of Male: _____ Female: _____ | | |

Applicant Name (Printed): _____ Title: _____

Applicant Signature: _____ Date: _____

*****DO NOT WRITE BELOW THIS LINE – SCHD USE ONLY*****

Facility Number: _____ Date Issued: _____

Date Expires: _____



Somerset County Health Department
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TDD 1-800-735-2258

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Statement of Compliance with Workers' Compensation Act

Maryland Health-General Code Annotated Section 1-202 requires that before any license or permit may be issued under the Health-General Article, the employer must submit a statement of compliance listing a workers' compensation insurance policy or binder number, or provide a Certificate of Compliance obtained from the Maryland Workers Compensation Commission (WCC).

To obtain a waiver, exclusion form or certificate of compliance from the WCC, please visit their website at <https://comphub.wcc.state.md.us/>.

Please check the box of the option below which applies to you, provide the requested information, sign and date the form, and return it with your application.

I have workers' compensation insurance:

Insurance Company _____
Policy or Binder Number _____

A waiver has been received from the Workers' Compensation Commission.
(ATTACH A COPY OF THE WAIVER)

I am exempt from having workers' compensation insurance per Maryland Labor and Employment Code Ann §9-206. (ATTACH A COPY OF THE EXCLUSION FORM)

I am self-insured. Approval of self-insurance has been received from the Workers' Compensation Commission. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE)

I have no employees; I am not required to carry workers' compensation insurance.

Printed Name

Title

Company Name

Company Address

Signature

Date