



APPLICATION FOR LICENSE TO OPERATE A FOOD SERVICE FACILITY

Application is hereby made to operate a food service facility in accordance with COMAR 10.15.03 Regulations Governing Food Service Facilities. Please select the appropriate priority category below and submit application with the associated fee. No fee will be assessed to a bona fide nonprofit organization as defined by COMAR 10.15.03.02.

- ☐ High Priority – **Fee: \$450**
- ☐ Moderate Priority – **Fee: \$350**
- ☐ Low Priority – **Fee: \$200**

For mobile food service facilities, please attach a renewed commissary agreement (required yearly).

Mobile Unit License Plate: _____

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):	Seating Capacity:	
Operation Is: <input type="radio"/> Permanent <input type="radio"/> Seasonal (from _____ to _____)	Water Supply: <input type="radio"/> Public <input type="radio"/> Private	Sewage Disposal: <input type="radio"/> Public <input type="radio"/> Private

Applicant Name (Printed): _____ Title: _____

Applicant Signature: _____ Date: _____

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

Facility Number: _____ Date Issued: _____
Priority: High Moderate Low Date Expires: _____

All fees are due at time of application and are a non-refundable filing and processing fee.



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