



# Wicomico County Health Department

108 East Main Street • Salisbury, Maryland 21801

*Matthew McConaughey, MPH, Health Officer*



## TEMPORARY FOOD EVENT COORDINATOR'S APPLICATION

(To be completed for events with three or more temporary food vendors)

Mail applications to: 108 E Main Street, Salisbury, MD 21801 Fax: 410-219-2882

The purpose of this application is to identify a point of contact for the event so that the Health Department can address any concerns in advance regarding food safety. This communication will assist you in promoting and achieving a successful event. This application must be completed by the event coordinator and returned to the Health Department at least 10 business days prior to the event.

**APPLICATION SUBMISSION DATE:** \_\_\_\_\_ **Property ID:** \_\_\_\_\_

**NAME OF EVENT:** \_\_\_\_\_

**LOCATION OF EVENT:** \_\_\_\_\_

**DATES & TIMES OF EVENT:** \_\_\_\_\_

**NAME OF RESPONSIBLE INDIVIDUAL/EVENT COORDINATOR FOR EVENT**

**NAME:** \_\_\_\_\_

**ADDRESS:** \_\_\_\_\_

**CITY:** \_\_\_\_\_ **STATE:** \_\_\_\_\_ **ZIP CODE:** \_\_\_\_\_

**TELEPHONE NUMBER:** \_\_\_\_\_

**CELL PHONE NUMBER (For Event):** \_\_\_\_\_

**FAX NUMBER:** \_\_\_\_\_

**EMAIL ADDRESS:** \_\_\_\_\_

**CONTACT INFORMATION FOR EACH TEMPORARY FOOD VENDOR:**

(Please distribute Temporary Food Event Application to all Food Vendors.)

FACILITY NAME	CONTACT NAME	ADDRESS	PHONE NUMBER

**(ATTACH ADDITIONAL SHEETS IF NECESSARY)**

410-749-1244 • FAX 410-543-6975 • TDD 410-543-6952

DEPARTMENT OF HEALTH AND MENTAL HYGIENE • 1-800-4MD-DHMH

AFFIRMATIVE ACTION AND EQUAL OPPORTUNITY EMPLOYER AND PROVIDER

ANTICIPATED NUMBER OF VISITORS PER DAY: \_\_\_\_\_

NUMBER OF TEMPORARY FOOD VENDOR BOOTHS: \_\_\_\_\_

DATE AND TIME FOOD VENDORS ARE READY FOR INSPECTION: \_\_\_\_\_

WILL ELECTRICITY BE PROVIDED TO THE VENDORS?  YES  NO

IF YES, PLEASE DESCRIBE HOW: \_\_\_\_\_

DESCRIBE POTABLE WATER SUPPLY: \_\_\_\_\_

**(IF WATER SOURCE IS A WELL, ATTACH THE RESULTS OF THE MOST RECENT WATER TEST. ENSURE FOOD GRADE HOSES & BACKFLOW PREVENTION PROVIDED.)**

DESCRIBE TOILET AND HANDWASHING FACILITIES PROVIDED BY EVENT: \_\_\_\_\_

WILL PORTABLE TOILETS BE USED DURING THE EVENT?  YES  NO

WHO WILL SERVICE (EMPTY) THEM DURING THE EVENT AND HOW OFTEN?: \_\_\_\_\_

DESCRIBE WASTEWATER/GREYWATER DISPOSAL SYSTEM: \_\_\_\_\_

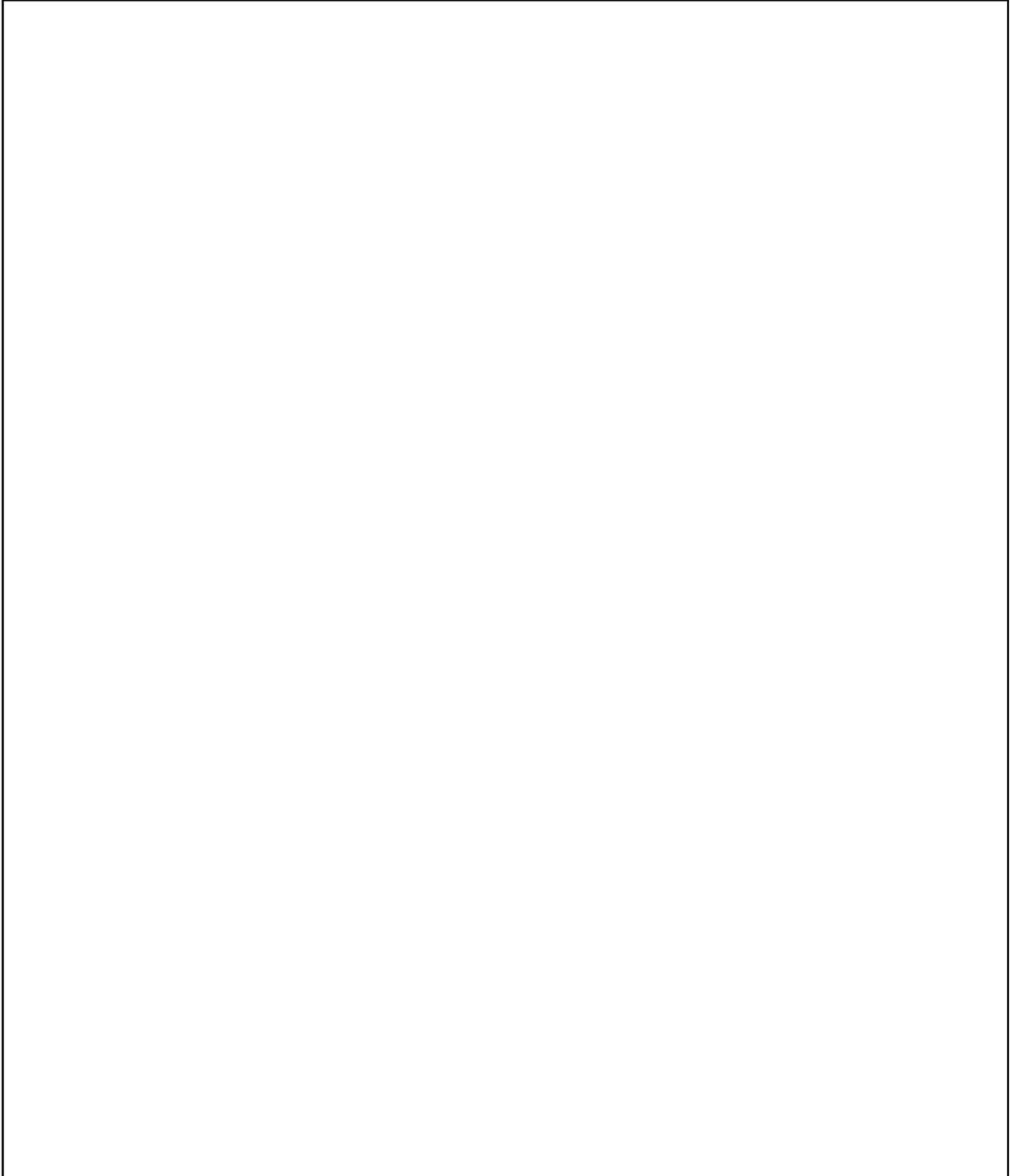
DESCRIBE GARBAGE DISPOSAL SERVICE: \_\_\_\_\_

**DESCRIBE RECYCLING PLAN: (RECYCLING STATIONS ARE REQUIRED FOR EVENTS WITH MORE THAN 200 EXPECTED ATTENDANTS. STATIONS MUST BE PROVIDED IMMEDIATELY ADJACENT TO EACH TRASH RECEPTACLE, MUST BE CLEARLY DISTINGUISHED FROM TRASH RECEPTACLES BY COLOR OR SIGNAGE, AND ALL RECYCLABLE MATERIALS DEPOSITED MUST BE COLLECTED FOR RECYCLING.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## SKETCH SHEET

In the following space, provide a drawing of the entire Temporary Event Area including locations of the toilet and hand washing facilities, garbage facilities, common use dishwashing facilities, the potable water supply, electrical sources, the waste water disposal area, and all food preparation and service areas on the ground/site of the Temporary Food Event.

A large, empty rectangular box with a thin black border, intended for a hand-drawn sketch of the Temporary Event Area. The box occupies the majority of the page below the instructions.

**STATEMENT:** I hereby certify that the above information is correct, and I fully understand that any deviation from the above without prior permission from the Wicomico County Health Department may nullify final approval.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Approval of these plans and specifications by the Wicomico County Health Department does not indicate compliance with any other codes, laws or regulations that may be required (i.e., federal, state, or local). Furthermore, it does not constitute endorsement or acceptance of the completed establishment (structure or equipment). A pre-opening inspection of the establishment with equipment in place and operational will be necessary to determine if it complies with the local and state laws governing food service establishments.

Health Department Reviewer Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Conditionally Approved:**       **Disapproved:**

Permit Restrictions – Reason(s) for Disapproval: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_