



# North Central District Health Department

- ☐ Enfield—31 North Main Street, Enfield, CT 06082 \* (860) 745-0383 Fax (860) 745-3188
- ☐ Vernon—375 Hartford Turnpike, Room 120, Vernon, CT 06066 \* (860) 872-1501 Fax (860) 872 1531
- ☐ Windham—Town Hall, 979 Main Street, Willimantic, CT 06226 \* (860) 465-3033 Fax (860) 465-3034
- ☐ Stafford—Town Hall, 1 Main Street, Stafford Springs, CT 06076 \* (860) 684-5609 Fax (860) 684-1768

**Patrice A. Sulik, MPH, R.S.**  
**Director of Health**

## MOBILE FOOD CARTS

Cart construction must be commercial grade and meet NSF standards or you can submit a cart design to our office for review prior to purchase. Most carts are made of stainless steel with a drop-in hand wash sink and cold storage cooler unit. Overhead protection is also required.

Depending on the town you wish to vend in, you may need to obtain Zoning approval and/or Police Department approval (Hawker's License, etc.). Each town in our District is a little different so be sure to check with individual departments in each member town. NCDHD Mobile Vendor's license is valid in our eight (8) member towns (Enfield, Ellington, East Windsor, Windsor Locks, Suffield, Vernon, Windham and Stafford).

Please find attached the following:

Mobile Vendor's Application which includes a Declaration of Base of Operations form (Base of Operation must be a licensed facility but does not have to be located in our District).

NCDHD and State Health Department Regulations for Mobile Vending.



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## APPLICATION FOR **SEASONAL** MOBILE VENDOR LICENSE

Date \_\_\_\_\_

Name on Vehicle \_\_\_\_\_

Name of Owner of Vehicle \_\_\_\_\_ E-mail: \_\_\_\_\_

Address of Owner \_\_\_\_\_ Phone No. \_\_\_\_\_

Mobile Vendor Plate No. \_\_\_\_\_

Name of Vehicle Operator \_\_\_\_\_

Vehicle Operator Phone No. \_\_\_\_\_ E-mail: \_\_\_\_\_

**Seasonal: Start Date:** \_\_\_\_\_ **End Date:** \_\_\_\_\_

Business Hours of Operation: \_\_\_\_\_

Business Locations \_\_\_\_\_

Location of Base of Operations \_\_\_\_\_

Type of Water Supply at Base of Operations:      Public Water      Private Well Water

Type of Sewage Disposal System:      Public Sewer:      On-Site Subsurface System

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Applicant's E-mail Address

\*\*\*\*\*

(FOR OFFICE USE ONLY)

License No. \_\_\_\_\_ Type of License \_\_\_\_\_ Fee Paid \$ \_\_\_\_\_

QFO Required \_\_\_\_ Yes \_\_\_\_ No      Operator QFO Certified: \_\_\_\_ Yes \_\_\_\_ No

Date of License \_\_\_\_\_ Approved \_\_\_\_\_ Disapproved \_\_\_\_\_

**\*\*\*FEE: See Fee Schedule – Attached\*\*\***

**Submit application to: [licenser renewals@ncdhd.org](mailto:licenser renewals@ncdhd.org)**

NORTH CENTRAL DISTRICT HEALTH DEPARTMENT  
**FEE SCHEDULE**

Approved at Regular Meeting of Board of Directors, September 13, 2017

**Effective September 14, 2017**

Category	Fee
Restaurants: Class 1	<b>\$150</b>
Class 2: 50 seats or less	<b>\$200</b>
51+ seats	<b>\$300</b>
Class 3: 50 seats or less	<b>\$300</b>
51+ seats	<b>\$400</b>
Class 4: 50 seats or less	\$300
51+ seats	\$400
Caterer	\$200
<b>Mobile Vendor:</b> FDA Class 1	<b>\$150</b>
FDA Class 2	<b>\$200</b>
FDA Class 3	<b>\$300</b>
FDA Class 4	<b>\$400</b>
<b>Seasonal: (six months or less) - Must have a Base of Operation</b> <i>Mobile Vendors can qualify for this with a license base of operation</i>	<b>\$100</b>
Retail Market: Under 5,000 square feet	\$200
5,000 square feet or more	\$400
Convalescent Home (Class 4)	<b>\$400</b>
Day Care Centers & Preschool Programs with Food Service License (Class 4)	<b>\$400</b>
Movie Theater	\$300
Private School	\$300
Other Food Service (not specified)	\$100
<b>Operating without a License (in violation of District Regulations)</b>	<b>\$400</b>
<b>LATE FEE: Operating with an expired license (Aligned with license fee)</b>	<b>\$150-\$400</b>
<b>Any failed inspection will result in a reinspection fee (Effective January 1, 2018)</b>	<b>\$150 each</b>
<b>For Food Service Establishments that initiate their license after May 1, 2018 (within 6 months of the license renewal date), that food service establishment will be charged one-half (50%) of the annual fee.</b>	<b>50% of \$150-\$400</b>
<b>Section 4 Compliance Inspection for New Owners</b>	<b>\$300</b>
Food Establishment Plan Review	\$400
Retail Market/Deli Plan Review	\$300
Factory, Private Educational Institution or Corp. Facility Food Plan Review	\$400

Mobile Vendor Food Service Application

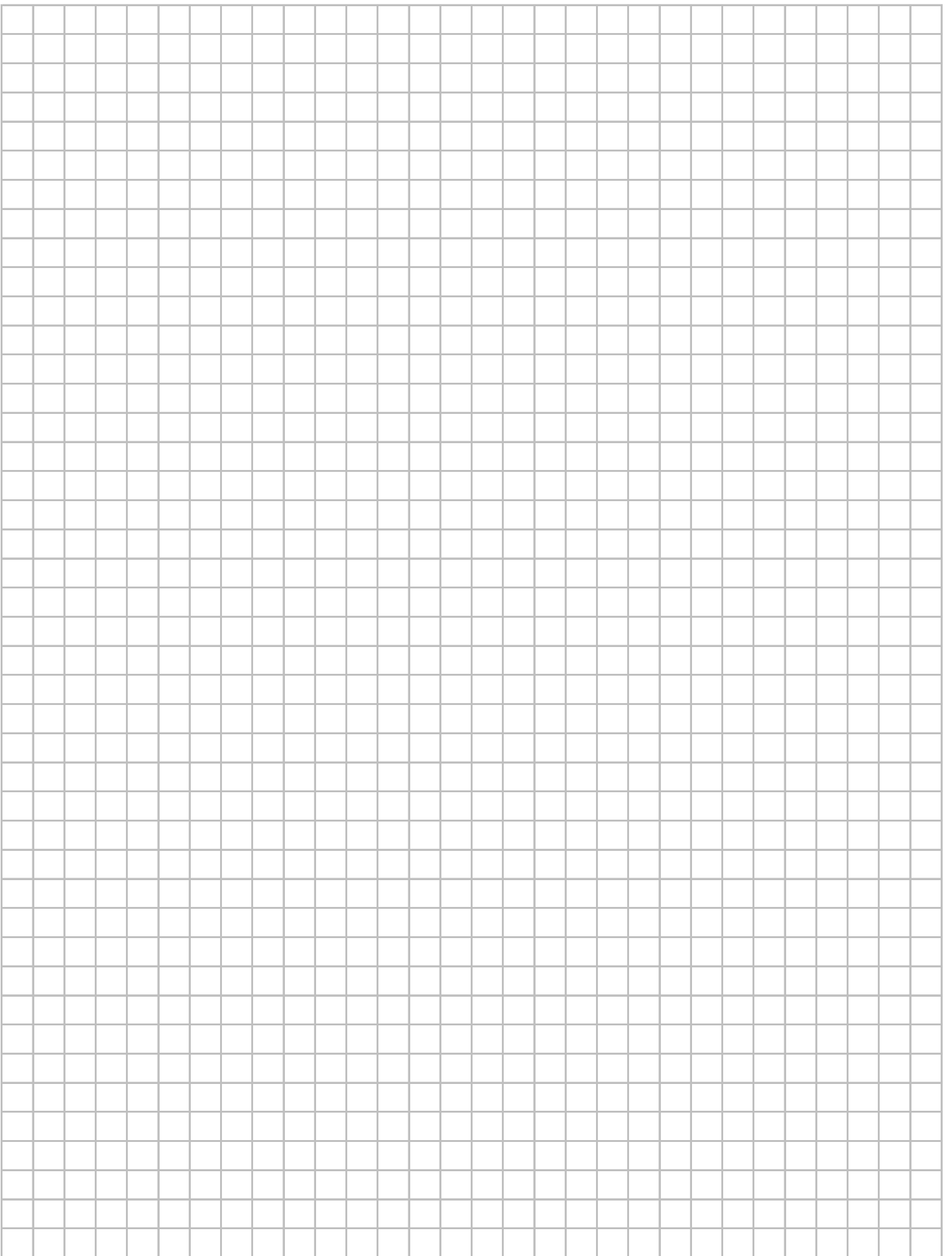
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1. What foods will be prepared, cooked and served out of the unit? \_\_\_\_\_  
\_\_\_\_\_
2. What foods will be prepared, cooked and possibly cooled at the Base of Operations? \_\_\_\_\_  
\_\_\_\_\_
3. What is the source of the food to be dispensed? Provide the Name and address of the food distribution facility used.  
\_\_\_\_\_
4. How will foods be kept hot or cold on the unit? (NOTE: The only accurate way to assure food temperatures are maintained safely at 135°F or above [for hot foods] or 41°F or below [for cold foods] is to use a metal stemmed probe thermometer.)  
\_\_\_\_\_  
\_\_\_\_\_
5. How and where will utensils, pans, etc., be cleaned at the end of the day? Be specific. \_\_\_\_\_  
\_\_\_\_\_
6. Describe the method of hand washing used at the unit. \_\_\_\_\_  
\_\_\_\_\_
7. Describe screening used for food protection: (NOTE: In larger units where food is prepared inside, screening is required to prevent the entrance of insects.)  
\_\_\_\_\_
8. How are water tanks filled? Where is waste water disposed? \_\_\_\_\_  
\_\_\_\_\_
9. Where will excess food and paper products be stored? \_\_\_\_\_  
\_\_\_\_\_
10. How will garbage be disposed on the units and at the Base of Operations?  
\_\_\_\_\_

Mobile Vendor Food Service Application  
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11. Is this mobile unit a commercially constructed unit? \_\_\_\_\_
12. What is covering the floor, walls and ceiling inside the unit? \_\_\_\_\_  
\_\_\_\_\_
13. Has this mobile unit been inspected and/or licensed by another Health Department? If yes, please identify. \_\_\_\_\_  
\_\_\_\_\_
14. Please provide a sketch of the mobile unit, drawn to scale, and include all equipment and equipment make and/or model specifications/information. All equipment must be commercial, NSF approved. Also, please provide any pictures of this mobile food unit. Use attached graph paper for sketch.

***Please contact the North Central District Health Department at least 48 hours in advance to have the mobile vending unit inspected prior to licensing or relicensing.***





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**Patrice A. Sulik, MPH, R.S.  
Director of Health**

## MEMORANDUM

November 30, 2000

### Requirements for a Qualified Food Operator Itinerant Food Vending

The State of Connecticut Public Health Code 2000, Section 1913-B48 Itinerant Food Vending specifically deals with the requirements of a qualified food operator and the classification of the establishments where these requirements apply. Enclosed you will find a photocopy of the applicable sections of this regulation.

Please refer to 19-13-B48 (j)(d)(3): "...Each person owning, operating or managing any itinerant food vending establishment designated a class III or class IV shall be a qualified food operator OR shall employ on-site at least one (1) qualified food operator who is in a supervisory position at said establishment..."

If the QFO is employed on-site in a supervisory position at your establishment, a copy of their QFO certificate must be maintained on site and also forwarded to the local Director of Health. The QFO shall be responsible for the training of food preparation personnel and shall maintain written documentation of training program, including the training records of individual employees. Refer to the specific sub-sections for additional information pertaining to these responsibilities.

Verification of QFO requirements will be checked at the time of inspection of your central kitchen/commissary (if applicable) and the mobile vending unit. If the central commissary is located outside of our jurisdiction, please have the QFO information for that establishment available at the time of inspection.



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## DECLARATION OF BASE OF OPERATION

This form must be submitted to the Health Department with your application for permit.

**PLEASE PRINT CLEARLY**

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

Business Name: \_\_\_\_\_

Owner/Operator Name: \_\_\_\_\_

Business Name of Base of Operation: \_\_\_\_\_

Address of Base of Operation: \_\_\_\_\_

Owner of Business Used as Base: \_\_\_\_\_

Owner's E-mail Address: \_\_\_\_\_

Telephone Number of Base of Operation: \_\_\_\_\_

### **THE FOLLOWING PORTION TO BE FILLED OUT BY THE OWNER OF THE FOOD ESTABLISHMENT USED AS THE BASE OF OPERATION.**

I, \_\_\_\_\_ attest that my licensed food establishment  
Owner of food establishment used as base

known as \_\_\_\_\_ is available as the base of operations for  
Name of food establishment

\_\_\_\_\_ owned by \_\_\_\_\_  
Name of Business Owner of Business

\_\_\_\_\_  
Signature of Owner of Food Establishment

**\*\*\*REMEMBER TO INCLUDE A COPY OF THE BASE OF OPERATION'S VALID FOOD PERMIT  
ISSUED BY THE LOCAL HEALTH DEPARTMENT\*\*\***

8/14/2019





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## GREASE TRAP QUESTIONNAIRE

Name of Food Service Facility: \_\_\_\_\_

Address of Facility: \_\_\_\_\_

This food service facility does not have a grease trap or grease interceptor.

This food service facility has an interior passive style grease trap.

Location: \_\_\_\_\_

Size: \_\_\_\_\_

Frequency of cleaning: \_\_\_\_\_

Contracted disposal with: \_\_\_\_\_

This food service facility has a large grease interceptor (exterior).

Location: \_\_\_\_\_

Size: \_\_\_\_\_

Frequency of Cleaning: \_\_\_\_\_

Contracted Cleaner: \_\_\_\_\_

**\*\*\* Attach a copy of your most recent grease trap pumper's report with this form.**

This food service facility has a mechanically cleaning BACT grease interceptor (i.e., Big Dipper, Highland Tank, etc.).

Please sign and fill in below:

Your Name: \_\_\_\_\_

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

Revised 9/22/09

**STATE OF CONNECTICUT DEPARTMENT OF PUBLIC HEALTH  
DRINKING WATER SECTION  
Food Service Establishment Water System Registration Form (Rev. 4/06)**

*Refer to instructions on reverse side for assistance in completing this registration form.*

Are there changes to property and/or food service establishment ownership/contact information from this past year?  Yes  No

**A. Food Service Establishment Information**

New food establishment licensure  Relicensure

Food Service Establishment Name: \_\_\_\_\_

Ownership information (food service establishment):

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature of food service establishment Owner: \_\_\_\_\_ Date: \_\_\_\_\_

**B. Water System Information**

What is the source of the water supply for this location?

Onsite Well

If 'Customer of a Community PWS', do not complete Section B.

Customer of a Community Public Water System (PWS)

Provide name of Community PWS: \_\_\_\_\_

Water System/Property Name \_\_\_\_\_ PWSID\*: CT \_\_\_\_\_

\* If known / if applicable

Address of Water System: \_\_\_\_\_ Town: \_\_\_\_\_

List all businesses and/or facilities supplied by water system: \_\_\_\_\_

Do at least 25 persons (including employees, customers, parishioners, visitors, etc., but not necessarily the same persons) visit the facilities/businesses supplied by the water system daily at least 60 days out of the year?  Yes  No

Total number of **same** persons who **regularly** use the facilities / businesses (i.e. employees, students, but not residents) for **at least 6 months a year**: \_\_\_\_\_ Avg. # of Daily Customers: \_\_\_\_\_ # of Residents: \_\_\_\_\_

Does this water system also supply water to a (check applicable):  hotel/motel  municipal bldg  gas station  
 medical facility  rest area  park/recreation area  campground  place of worship  Other: \_\_\_\_\_

Type and number of wells:  Drilled Wells \_\_\_\_\_  Shallow Dug Wells \_\_\_\_\_  Other: \_\_\_\_\_

Installed water treatment equipment:  Iron/manganese filter  Ultraviolet light  Water softener  Aeration  
 Granular Activated Carbon filter  Acid Neutralizer  Other/Unk: \_\_\_\_\_  Chemical feed: \_\_\_\_\_

Water System annual operating period (begin/end dates of operation): From: \_\_\_\_\_ To: \_\_\_\_\_  
month/day month/day

Water system ownership information (i.e. property owner):

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Signature of Property Owner: \_\_\_\_\_ Date: \_\_\_\_\_

***Information below to be completed by the Local Health Department***

1. Date: \_\_\_\_\_

2. Water System Classification (check one):  NTNC  TNC  NP  Undetermined  CWS Customer\*

3. Reviewed by (print name, title and LHD): \_\_\_\_\_

4. Signature: \_\_\_\_\_

Mail a copy of the completed registration form to:

CT Department of Public Health – Drinking Water Section, CRS Unit,  
410 Capitol Ave. MS#51WAT, P.O. Box 340308, Hartford, CT 06134-0308

\* If CWS customer, do not forward form to CT DPH – DWS.

### Instructions for Completing Registration Form

This form is to be used for food service establishments who will or do occupy a building with a well water system. This form is to be used during new food service establishment licensure and existing food service establishment relicensure. Sections A and B of this form are to be completed by the food service establishment applicant, and returned to the respective Local Health Department for review and transmission to the Drinking Water Section of the Department of Public Health. Section B is to be completed by the Local Health Department.

**A. Food Service Establishment Information:** This information is to be provided by the food service establishment applicant. Check if there are any changes in ownership, or contact information (i.e., phone #, address, ownership, contact information, etc.). ***New food service establishment licensure / Relicensure*** – check either new licensure or relicensure. ***Food Service Establishment Name*** – list the business name of the food service establishment. ***Ownership information*** – enter the name, mailing address, phone number and dated signature of the owner of the food service establishment. If the owner is a corporation then the name of a contact person must also be provided.

**B. Water System Information:**

***What is the source of the water supply for this location?*** – Indicate (check) whether this establishment is served by its own well or is a customer of Community Public Water System (CWS).

\*Only continue completing Section B if the food service establishment receives all or part of its water supply from a source other than a regulated CWS. If the food service establishment does not own the water system (i.e. leased space) then the information in Section B may need to be obtained from the property owner.

***Water System/Property Name*** – provide the name that best describes the water system. In cases where the water system serves only the food service establishment, provide the business name of the food service establishment. If the water system serves a shopping plaza provide the name of the shopping plaza. If the water system serves multiple properties provide the name that best describes the water system (example: 156-159 Main Street). Provide the Public Water System (PWS) identification #, if known or if applicable.

***Address of Water System*** – list the address(es) of the property(ies) being served by the well water system.

***Town*** – list the town in which the water system is located.

***Businesses and/or facilities supplied by water system*** – list the name of all businesses, or other facilities served by the water system.

***Do at least 25 persons visit the facilities/businesses supplied by the water system daily at least 60 days out of the year?*** – The availability of water would include public restrooms and/or foods or beverages prepared with water. Check yes or no.

***Total number of same persons who regularly use the facilities/businesses for at least 6 months a year*** – provide the number of persons (i.e. employees, students, NOT residents or transient customers) who use the facility on a daily basis at least 6 months out of the year. Provide an average number of customers who visit your facility/business on a daily basis. Provide the number of residents who live at the facilities/businesses.

***Does this water system also supply water to a (check any that apply)*** – check any of the applicable categories. If an applicable category is not provided, check other and provide a description of the type of facility the water system supplies.

***Type and number of wells*** – provide the number of wells for each applicable category in the space provided, when using the “Other” category also provide a description of the type of water source.

***Installed water treatment equipment*** – check any water treatment equipment installed on the water system. When checking chemical feed systems also list the type of chemical that is being added to the water (example: chlorine, soda ash, permanganate).

***Water system annual operating period (begin/end dates of operation)*** – provide the beginning and end dates (month and day) of the season of operation for the water system, if the water system operates year round enter from 1/1 to 12/31.

***Water system ownership information*** – enter the name, mailing address, phone number and signature for the **property owner** of the water system that will provide water service to the food service establishment. This may be the same information as the owner of the food service establishment, or it may be the name of the landlord, owner of a shopping plaza, etc. If the owner is a corporation then the name of a contact person must also be provided.

**Information to be completed by the Local Health Department:**

1. ***Date*** – date of review.
2. ***Water System Classification (check one)*** – check the water system classification based on information provided in Section B (Water availability to 25 or more persons/day for at least 60 days/year, and # of employees, residents, etc.).
  - If the system regularly serves at least 25 of the **same** persons (not including residents or transient persons) per day for 6 months or more a year, then check **NTNC**.
  - If the system does not supply water to at least 25 persons for at least 60 days out of the year, then check **NP**.
  - If the system is served only by a Community Public Water System (Section B is N/A), then check **CWS Customer**.
  - If the system serves 25 or more persons, at least 60 days a year, and does not meet any of the above, then check **TNC**.\*For additional information on classification, refer to <http://www.dph.state.ct.us/BRS/water/Consumer/PWS.htm>
3. ***Reviewed by (print name and title)*** – provide the name and title of the local health official reviewing the registration form. This person must be a registered sanitarian or the local director of health.
4. ***Signature*** – signature of the person (registered sanitarian or local director of health) reviewing the registration form.