

Clark County Health Department
997 N. York St.; P.O. Box 266
Martinsville, IL 62442
Ph# (217) 382-4207
Fax# (217) 382-4226

For Office Use Only:
Establishment # _____
CK/MO# _____
Received _____

Please complete the form as applicable and return with the food permit fee amount as stated in the cover letter.

Name of Establishment _____
Address of Establishment _____ City _____ Zip _____
Address to Send Permit _____ City _____ Zip _____
Phone Number _____ Fax Number _____
Owner/Manager to Appear on Permit _____
Emergency Phone Number _____ E-mail Address _____
Website Address: _____

Individually Owned Firm or Corporation Partnership Not For Profit

Type of Establishment (Check all that apply):

Restaurant Delicatessen Tavern with Kitchen Tavern
 Catering Retail Food (Groceries) Bakery Other: _____

Please list any changes in your establishment within the last year:

If No Longer Operating, Provide Close Date: _____
 Structure: _____
 Menu (If changed, include new menu w/ application): _____
 Number of Seats: _____ Square Footage of Building: _____

Facility Hours:

Monday _____ Tuesday _____ Wednesday _____ Thursday _____
Friday _____ Saturday _____ Sunday _____

Do you close for an extended period of time? Yes No
If yes, what dates: From _____ Through _____

Certified Food Service Sanitation Manager(s). Use back of page if more space is needed.
(List even if previously submitted or there have been no changes).

Name: _____ Number _____ Expiration date: _____
Name: _____ Number _____ Expiration date: _____

Application is hereby made for a Retail or Food Service Establishment within Clark County, Illinois. By this application it is agreed to comply with the provisions of the Basic Sanitation Standards applicable to this type of food handling establishment and that said establishment will be open to inspection by the Clark County Health Department during all operation hours. It is further agreed that an annual inspection fee may be applicable. It is also agreed to notify the Health Department of any changes to the facility or closure of the establishment.

Applicant Signature: _____ Date: _____

THE CLARK COUNTY HEALTH DEPARTMENT NEEDS TO BE NOTIFIED OF ANY CHANGES TO HOURS, MENU, EQUIPMENT OR STRUCTURE. A PLAN REVIEW IS NECESSARY FOR SOME CHANGES.