STANDARD APPLICATION FOR NEW LICENSE OR PERMIT

(For detailed instructions and information about what is required to apply for this permit, please go to www.nyc.gov/healthpermits)



NAME OF LICENSE/PERMIT

APPLICATION DATE								
MONTH	DAY	YEAR						

FOR OFFICE USE										
CAMIS/RECORD NUMBER					LICENSE/PERMIT					
					TY	/PE	FEE CLASS/ SUBCLASS			
					н					
EXPIRATION DATE					FEE	DOL	LARS	CENTS		
МО	DAY	YEAR			AMOUNT					
					A					

IMPORTANT: Please abbreviations are peri					ow spaces b	etween comp	leted wo	rds or nu	ımbers. S	Standar	rd		
SECTION A - NAME, ADDRESS AND CONTACT INFORMATION OF ENTITY TO WHICH LICENSE/PERMIT IS TO BE ISSUED													
READ CAREFULLY: Enter the corporate name and location of business establishment. If not incorporated, enter your name(s) and location of business establishment.													
NAME OF CORPORATION	N, PARTNERSHIP,	PARTNERS C	R INDIVIDUA	L OWNER (Las	st Name First)	TELEPHONE N	NUMBER						
						(AREA CODE)	1 1			1 1	1 1	ĺ	
TRADE NAME/Doing Bus	siness As (DBA)					FAX NUMBER	FAX NUMBER						
						(AREA CODE)	1 1				1 1	1	
BUILDING NUMBER	STREET					PREMISES LOCATION (FLOOR, STORE #, BOOTH #)							
CITY OR TOWN STATE ZIP CODE						E-MAIL ADDRESS							
DATE OF BIRTH		MONTH	DAY	Y	EAR	OPTIONAL							
(If applying as an indi-	vidual)					GENDER:							
Language Preference for Inspections: If the permit you are applying for requires an inspection by the Department of Health and Mental Hygiene, do you prefer that this inspection be conducted in, or translated to, a language other than English? No Yes If "yes" that language is									ou				
☐ I agree to receive all official notices from the Department of Health only by email at the email address provided in this application form. An official notice is any correspondence from the Department of Health that requires a response by a date certain. These include, but are not limited to, permit or license renewal notices; notices of fines or fees owed; collection letters and Dunning Notices, and Notices of Violations.													
☐ I would like to receive Department of Health publications, including information about new regulations, newsletters, fact sheets and other educational material, only by email at the email address provided in this application form.													
					ECURITY NUMBER ITIN NUMBER (If no SSN and applying as an individual)								
MONTH DAY	YEAR												
SECTION D - MAILING ADDRESS, IF DIFFERENT FROM PERMITTED/LICENSED ESTABLISHMENT'S ADDRESS (INCLUDE APARTMENT #, PO BOX #)									—— X #)				
STREET ADDRESS	· · · · · · · · · · · · · · · · · · ·									<u> </u>			
CITY OR TOWN								STATE		ZIP CC	DDE		

CITYWIDE LICENSING CENTER - DEPARTMENT OF HEALTH AND MENTAL HYGIENE - 42 BROADWAY, NEW YORK, NY 10004

5	SECTION	E - LIST NAMES (LAST, FIRST) OF OWNER - PAR	TNER - CC	RPORATE O	FFICERS				
	NAME		PHONE NUMBER		E-MAIL ADDRESS		TITLE		
1		STREET		CITY		STATE	ZIP CODE		
	ADDRESS		PHONE NUMBER E-MAIL ADDRESS CITY STATE PHONE NUMBER E-MAIL ADDRESS CITY STATE PHONE NUMBER E-MAIL ADDRESS CITY STATE PHONE NUMBER E-MAIL ADDRESS CITY STATE PHONE NUMBER E-MAIL ADDRESS CITY STATE CITY STATE CITY STATE PHONE NUMBER E-MAIL ADDRESS CITY STATE CITY ST						
	NAME		PHONE	NUMBER	E-MAIL ADDRESS		TITLE		
2	ADDRESS	STREET	ı	CITY		STATE	ZIP CODE	<u> </u>	
	NAME		PHONE	NUMBER	E-MAIL ADDRESS	I	TITLE		
3	ADDRESS	STREET	l	CITY		STATE	ZIP CODE	<u> </u>	
	NAME		PHONE	L NUMBER	E-MAIL ADDRESS	l	TITLE		
4	ADDRESS	STREET		CITY		STATE	ZIP CODE	 <u> </u> 	
,	SECTION	F							
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	COPIES C YOUR API AND PROP Please che	OF PROOF OF CURRENT INSURANCE IF IT IS REQUITED FOR A PERMIT WILL NOT BE ACCEPTED OF IF YOU ARE REQUIRED TO HAVE THIS INSURABLE OF IT APPROPRIES TO THE REQUIRED TO HAVE THIS INSURABLE OF THE REPORT OF THE PROPRIES OF THE P	OUIRED. ED IF YOU ANCE.	DO NOT CO	MPLETE THIS SEC	TION AND PR	OVIDE THIS I		
١	Workers' (Compensation Insurance Carrier:		Policy	#:	E	xpiration Date	:	
Disability Benefits Insurance Carrier: ————————————————————————————————————								:	
[CE-200 was submitted to the Worker's Compensation e-assigned Exemption Certificate Number is attache		ating such co	verage is not require	ed for this busi	ness and a co	py with the New	
(Certificate	Number: Issuan	ice Date: _						
F	Form CE-2	200 attesting to an exemption of this requirement ca		d at http://ww	w.wcb.ny.gov				
		sons for an applicant to qualify for this exemption and the emption and is not required to obtain Workers' Com					see if your bu	usiness qualifies	
		g this application for a permit, I agree that I will comply ode and other laws that apply to the permitted ac			TITLE			ARE YOU	
statements made in this application are true and complete. Making a false statement is an offense punishable by fines, i (NYC Administrative Code § 10-154.)			•					18 YEARS OF AGE OR OVER?	
ľ		SIGNATURE OF BUSINESS OWNER, PARTNER, OR	CORPORAT	E OFFICER	TELEPHONE NUMBI	ER		YES	
SIGN HEDE					NO				

ARE YOU REGISTERED TO VOTE?

If not, you may request a Voter Registration form when you submit your application, or you can access www.nyccfb.info/registertovote online.