CAROLINE COUNTY HEALTH DEPARTMENT
Caring for Caroline

Division of Environmental Health

403 S. 7th Street; Rm 248, Denton, MD 21629

Health Officer, Laura Fretterd Patrick, RN, BSN, MS

Caroline County Health Department
Mobile Reciprocity Food Permit Application

Application is hereby made to operate a mobile food service operation in accordance with COMAR 10.15.03

SUBMIT COMPLETED FORM 3-WEEKS PRIOR TO OPERATING IN CAROLINE COUNTY

The Caroline County Health Department reserves the right to deny an incomplete or fraudulent license application.

A license application received without a fee will not be processed.

Do you have a "County of Origin: Mobile Food License? ☐Yes ☐No *(If no, you do not qualify for reciprocity)*

If you selected "Yes", please provide the following documents for approval of reciprocity mobile license:

- **Copy of Food License issued by the "County of Origin" and most recent Inspection Report**
- **Menu and Approved HACCP Plan**
- **Commissary or Base Operation Authorization document**
- **Copy of Vehicle Registration**
- **Completed statement for Worker's Compensation Compliance**

Mobile Type: ☐Mobile Trailer Unit ☐Mobile Truck ☐Push Cart ☐Pre-Packaged Ice Cream Only

Please print clearly

Facility Name:	Owner's Name:
Business Name: (INC. or LLC)	Mailing Address:
Mobile Tag #:	City, State, ZIP:
Name of Base of Operation:	Phone Number:
Base of Operation Address:	Email Address:
Vehicle License Plate Tag #:	Vehicle VIN #:
Business Operation: ☐ Permanent/Year-Round ☐Seasonal (Operating Dates) _____	Days of Operation: Times of Operation:
Water Supply: ☐Public ☐Private	Sewage Disposal: ☐Public ☐Private
Set up location(s):	

I have examined and read the above application and attached requirements and I agree to comply with all applicable laws, regulations, and requirements including, but not limited to, the State of Maryland and Caroline County in operating a food service facility. I understand that falsification of this application may result in the denial, suspension, or revocation of the license.

Authorized Signature: _____ Title: _____ Date: _____

----------**Health Department Use Only**----------

Date Received: Fee Due: Receipt #:	☐ Approved ☐ Denied Date Issued (if approved):	Priority Assessment: ☐High Priority ☐Moderate Priority ☐Low Priority Reviewed By:

Created – August 2017; revised Oct. 2017; Dec. 2020