SAN BERNARDINO COUNTY
Public Health
Environmental Health Services

385 N. Arrowhead Ave., 2nd floor, San Bernardino, CA 92415
Email: EHS.CustomerService@dph.sbcounty.gov
Website: wp.sbcounty.gov/dph/ehs
Text/Call: 800.442.2283
Fax: 909.387.4323

APPLICATION FOR TRANSFER OF OWNERSHIP

THIS SECTION IS TO BE COMPLETED BY APPLICANT/ HEALTH PERMITS ARE NOT TRANSFERABLE

FACILITY INFORMATION

First Date of Operation:	Former Facility Name:		
Facility Name:		Phone Number:	
Address:	City:	State:	Zip:

LEGAL OWNER INFORMATION

New Legal Owner:		Phone Number:	
Email Address:			
Mailing Address:	City:	State:	Zip:

BILLING INFORMATION

Last Name:	First Name:		
Billing Address:	City:	State:	Zip:

PROVIDE FACILITY DETAILS

Has the facility been closed more than six (6) months?	☐ Yes ☐ No
Does the facility have a dedicated mop/janitorial sink?	☐ Yes ☐ No
Are there any changes to the current menu/food sold?	☐ Yes ☐ No
Does the facility have restroom(s)? How many?	☐ Yes ☐ No
Is there any sit down service?	☐ Yes ☐ No
Does the facility have hand wash sink(s)? How many? Location(s):	☐ Yes ☐ No

Seating Capacity:	Square Footage:	Max Number of Employees per Shift:

CHECK ALL THAT APPLY

Existing Equipment: ☐ Three-Compartment sink ☐ Two-Compartment sink ☐ Dish machine ☐ Prep sink drainboard (produce sink)	Water heater type and rating: ☐ Gas BTU: _____ or ☐ Electric KW: _____
	Approved water source provided by: ☐ Municipal Water or ☐ Onsite (Well) Connection
	Waste water disposal provided by: ☐ Public Sewer or ☐ Onsite Wastewater Treatment System (OWTS)

DESCRIBE ANY PROPOSED CHANGES AND/OR REPAIRS

Has the facility had any changes or repairs to equipment, floors, walls, ceiling, storage areas or dining area since the New Legal Owner has assumed ownership? If yes, describe below.	☐ Yes ☐ No

DECLARATION AND SIGNATURE

ALL FEES ARE DUE AND PAYABLE PRIOR TO THE FIRST DAY OF OPERATION.
Make checks payable to: SAN BERNARDINO COUNTY

Application and fee must be submitted prior to operation by any new owner. Failure to pay within 30 days of the first day of operation will result in the assessment of a delinquent fee.

Indemnification: The Contractor agrees to indemnify, defend (with counsel reasonably approved by County) and hold harmless the County and its authorized officers, employees, agents and volunteers from any and all claims, actions, losses, damages, and/or liability arising out of this contract from any cause whatsoever, including the acts, errors or omissions of any person and for any costs or expenses incurred by the County on account of any claim except where such indemnification is prohibited by law. This indemnification provision shall apply regardless of the existence or degree of fault of indemnitees. The Contractor's indemnification obligation applies to the County's "active" as well as "passive" negligence but does not apply to the County's "sole negligence" or "willful misconduct" within the meaning of Civil Code Section 2782.

I shall notify this agency in writing if I transfer ownership, discontinue operation or change billing address. Failure to do so may result in obligation to pay health services fees and additional penalties.

I HEREBY MAKE APPLICATION FOR HEALTH SERVICES AND PERMIT to establish and/or operate the above mentioned business, use, or services in accordance with the laws, ordinances, and regulations that are now or may hereinafter be in force by the United States government, the State of California, and San Bernardino County pertaining to the above mentioned business. I hereby consent to all necessary inspections incident to the issuance of this permit and operation of the business.

_____**Initials** I understand that any construction, alteration or repair including, but not limited to, equipment changes or alterations, a menu change or change in facility's method of operation requires EHS review and approval.

☐ Electronic Signature Only: By checking this box, I confirm I am submitting this application electronically and that the information on this form is true and correct. I also acknowledge that I have read, understand and accept any terms and conditions of this form.	Date:
Signature:	Date:
Print Name:	Title:

For Office Use Only

Late Fee: ☐ Y ☐ N	Fee:	Date:	Received By:
Designated Employee:		Record ID:	
FA Number:		PE Number:	

Check One: ☐ New ☐ Transfer ☐ Reactivate

Changes (please specify):

☐ Approved For Transfer ☐ Billable Field Consultation Required ☐ Transfer Denied

EHS Reviewer: