



APPLICATION FOR TRANSFER OF OWNERSHIP

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

FACILITY INFORMATION

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

LEGAL OWNER INFORMATION

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

BILLING INFORMATION

Last Name	First Name		
Billing Address	City	State	Zip

DESCRIBE ANY PROPOSED CHANGES AND/OR REPAIRS

FACILITY DETAILS

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Any changes or repairs to equipment, floors, walls, ceiling, storage areas or dining area? If yes, describe above	<input type="checkbox"/>	<input type="checkbox"/>	Are there any changes to the current menu/food sold?
<input type="checkbox"/>	<input type="checkbox"/>	Closed more than six (6) months?	<input type="checkbox"/>	<input type="checkbox"/>	Restroom(s)? How many?
<input type="checkbox"/>	<input type="checkbox"/>	Dedicated Mop/Janitorial sink?	<input type="checkbox"/>	<input type="checkbox"/>	Is there any sit down service?
<input type="checkbox"/>	<input type="checkbox"/>	Hand wash sink(s). How many?	Location(s)		
Seating Capacity		Square Footage	Max Number of Employees per Shift		

CHECK ALL THAT APPLY

Existing Equipment:	<input type="checkbox"/> 3-Compartment sink	<input type="checkbox"/> 2-Compartment sink	<input type="checkbox"/> Dish machine	<input type="checkbox"/> Prep sink drain board (produce sink)	
Water heater type and rating	<input type="checkbox"/> Gas	BTU	or	<input type="checkbox"/> Electric	Kw
Approved water source provided by	<input type="checkbox"/> Municipal Water	or	<input type="checkbox"/> Onsite (Well) Connection		
Waste water disposal provided by	<input type="checkbox"/> Public Sewer	or	<input type="checkbox"/> Onsite Wastewater Treatment System (OWTS)		

**ALL FEES ARE DUE AND PAYABLE PRIOR TO 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.

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 the County of San Bernardino 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.

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. **Initial** _____

Signature X		Date	
Print Name		Title	
For Office Use Only		For Office Use Only	
Fee:	FA Number:	Record ID:	PE Number:
Late Fee: <input type="checkbox"/> Y <input type="checkbox"/> N	Designated Employee:	Received By:	Date:
Check One: <input type="checkbox"/> New	<input type="checkbox"/> Transfer	<input type="checkbox"/> Reactivate	Changes (please specify):
<input type="checkbox"/> APPROVED FOR TRANSFER		<input type="checkbox"/> BILLABLE FIELD CONSULTATION REQUIRED	
<input type="checkbox"/> TRANSFER DENIED			
DEHS Reviewer:			