



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?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the facility have a dedicated mop/janitorial sink?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any changes to the current menu/food sold?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the facility have restroom(s)? How many?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Is there any sit down service?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the facility have hand wash sink(s)? How many? Location(s):			<input type="checkbox"/> Yes <input type="checkbox"/> No
Seating Capacity:	Square Footage:	Max Number of Employees per Shift:	
CHECK ALL THAT APPLY			
Existing Equipment: <input type="checkbox"/> Three-Compartment sink <input type="checkbox"/> Two-Compartment sink <input type="checkbox"/> Dish machine <input type="checkbox"/> Prep sink drainboard (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)			
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.			<input type="checkbox"/> Yes <input type="checkbox"/> 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.

<input type="checkbox"/> 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:
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Signature:	Date:
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Print Name:	Title:
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For Office Use Only

Fee	FA Number:	Record ID:
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Late Fee: <input type="checkbox"/> Y <input type="checkbox"/> N	PE Number:	SR Number:
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Designated Employee:	Received By:
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Check One: <input type="checkbox"/> New <input type="checkbox"/> Transfer <input type="checkbox"/> Reactivate	Date:
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Changes (please specify):

Approved For Transfer
 Billable Field Consultation Required
 Transfer Denied

EHS Reviewer: