



# KENDALL COUNTY/CITY OF BOERNE

## RETAIL FOOD OPERATION PERMIT APPLICATION



**Mail to:**  
**201 E. San Antonio St., Suite 304, Boerne, Texas 78006**  
**Make checks payable to: Kendall County**

Retail Food Operation

Permit # Issued \_\_\_\_\_

**1. Type of Food Operation**

<input type="checkbox"/> Retail Food Store	-Permit is valid for one year
<input type="checkbox"/> Food Service Establishment	-Permit is valid for one year
<input type="checkbox"/> Mobile Food Unit	-Permit is valid for one year (Mobile Food Service Units are subject to inspection prior to issuance of permit)
<input type="checkbox"/> Hotel/Motel Food Service	-Permit is valid for one year
<input type="checkbox"/> Day Care Center	-Permit is valid for one year

<p><b>2. Certified Food Manager</b>    <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p>CFM Name: _____</p> <p>CFM ID: _____</p> <p>CFM Expiration: _____</p> <p><i>Failure to have a CFM employed by your establishment will result in a citation or suspension of your food permit.</i></p>	<p><b>3. Amended Permit</b>    <input type="checkbox"/> yes    <input type="checkbox"/> no</p> <p><input type="checkbox"/> Change of Ownership</p> <p><input type="checkbox"/> Change of Name</p> <p><input type="checkbox"/> Change of Location</p> <p><input type="checkbox"/> Effective Date of Change: _____</p> <p><i>Change of name, ownership or change in location of a licensed place of business, requires submission of new application and fee.</i></p>
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**4. Complete in Full:**

Name of Business: \_\_\_\_\_ Tax ID# \_\_\_\_\_

Legal Name of Owner if different from above \_\_\_\_\_

Location Address: \_\_\_\_\_  
Address City/State Zip Code

Mailing Address: \_\_\_\_\_  
Address City/State Zip Code

Contact Person regarding permit: \_\_\_\_\_ Telephone No. \_\_\_\_\_

Manager \_\_\_\_\_ Telephone No. \_\_\_\_\_

<b>Gross Annual Income of Food Establishment:</b>	<b>Annual Fee:</b>	<input type="checkbox"/> <b>Late Fee</b> - A person who files renewal application after the expiration date will be accessed late charges of <b>\$5.00 per day.</b>
<input type="checkbox"/> \$0.00-\$24,999.99	<input type="checkbox"/> \$100.00	<b>Fees are non-refundable.</b>
<input type="checkbox"/> \$25,000.00 - \$49,999.99	<input type="checkbox"/> \$125.00	
<input type="checkbox"/> \$50,000.00 - \$149,999.99	<input type="checkbox"/> \$200.00	
<input type="checkbox"/> \$150,000.00 - or more	<input type="checkbox"/> \$300.00	
<input type="checkbox"/> Day Care Centers	<input type="checkbox"/> \$ 75.00	

**5. Check type of ownership and provide required information:**

Proprietorship - Name of Proprietor \_\_\_\_\_

Partnership - Names of all Partners \_\_\_\_\_

Association - Names of all Principals \_\_\_\_\_

Corporation - Names of Officers and Directors \_\_\_\_\_

Date and Place of Incorporation \_\_\_\_\_

Name and Address of Registered Agent in State \_\_\_\_\_

**6. Profile:**

Hours of Operation: Start \_\_\_\_\_ Finish \_\_\_\_\_ Days Open: \_\_\_\_\_

**VERIFICATION:** I CERTIFY THAT ALL INFORMATION IN THIS APPLICATION IS TRUE AND CORRECT. IF THE OWNER IS A CORPORATION, I FURTHER CERTIFY THAT I AM AUTHORIZED TO EXECUTE THIS DOCUMENT ON BEHALF OF THE CORPORATION. I FURTHER CERTIFY THAT I HAVE READ AND UNDERSTOOD CHAPTER 437 OF THE HEALTH & SAFETY CODE, THE APPLICABLE PROVISIONS OF 25 TAC, CHAPTER, 229, AND AGREE TO ABIDE BY THEM. I UNDERSTAND THAT PROVIDING FALSE, INCORRECT OR INCOMPLETE INFORMATION ON THIS APPLICATION SHALL BE GROUNDS FOR DENIAL OR CANCELLATION OF A PERMIT.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name & Title \_\_\_\_\_

OWNER

PARTNER

PRESIDENT

CORPORATE DESIGNEE/AGENT