ST CLAIR COUNTY HEALTH CENTER
SEASONAL FOOD PERMIT APPLICATION

Date: _____

Name: _____

Address: _____

City, State, Zip: _____

Event Periods: _____

Phone Number: _____

Person In Charge of Fundraiser: _____

Types of Food being served: _____

Date of Food Class Attendance: _____

Date of Inspection by Sanitarian: _____

I certify that the above information on this form is true and correct and I understand that false statements are punishable under Missouri law.

Organizations Representatives Signature:

_____ Date: _____