

**Macon County Health Dept.**  
 1221 E. Condit Street, Decatur, IL 62521  
 Phone (217) 423-6988 Fax (217) 423-0992



**Public Health**  
 Macon County  
 Health Department

**\* PLEASE DO NOT WRITE IN THIS BOX \***

New? Y or N    New Folder \_\_\_\_\_    Put In Computer \_\_\_\_\_  
 Notify Inspector \_\_\_\_\_  
 Lic Fee: \_\_\_\_\_    Check#: \_\_\_\_\_    Or Cash?   
 Date Payment Rec: \_\_\_\_\_    Initials: \_\_\_\_\_  
 Date Lic Mailed: \_\_\_\_\_    Given in Office? \_\_\_\_\_

**Application to Operate a  
 Mobile Food Unit**

FOR LICENSE YEAR: \_\_\_\_\_ **(PLEASE PRINT)**    Emergency Ph#: \_\_\_\_\_

Name of Establishment: \_\_\_\_\_ Phone: \_\_\_\_\_

Location Address: \_\_\_\_\_

(Attach a separate sheet if necessary to list all locations and dates)

Contact Person/Owner: \_\_\_\_\_ Phone: \_\_\_\_\_

Contact Person/Owner Address: \_\_\_\_\_  
 \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**CERTIFIED FOOD PROTECTION MANAGER & EXPIRATION DATE REQUIRED**

Name \_\_\_\_\_ Certificate ID #: \_\_\_\_\_ Exp. Date \_\_\_\_\_

Name \_\_\_\_\_ Certificate ID #: \_\_\_\_\_ Exp. Date \_\_\_\_\_

I affirm that the above information is true to the best of my knowledge and belief. (Please sign by star)



Applicant's Signature

Date

**Establishment Classification and Permit Fee**

General Food Permits	Fee	1st Time Permit w/ Plan Review Surcharge	
			After 6/30
Class A - Category 1	\$550	\$700	\$550
Class B - Category 2	\$350	\$500	\$350
Class C - Category 3	\$200	\$275	\$200

**REMINDER:**  
*Category 1 Mobile Food Units must submit a commissary letter each year.*

**VARIANCE:**  
 \_\_\_\_\_ YES    \_\_\_\_\_ NO

**Do Not Write Below This Line. For Official Use Only.**

ZONE: _____  CLASS _____  CATEGORY _____	_____ Environmental Health Practitioner, Macon County Health Department	_____ Date
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