



SEMINOLE TRIBE OF FLORIDA
Environmental Health Program/Health Administration
6365 Taft Street, Suite 1004, Hollywood, Florida 33024
954-985-2330 - www.semtribe.com

Check Type
<input type="checkbox"/> New Application
<input type="checkbox"/> Renewal

Fiscal Year: _____

FOOD SERVICE LICENSE APPLICATION

ESTABLISHMENT INFORMATION

ESTABLISHMENT NAME: _____

ESTABLISHMENT ADDRESS: _____

ESTABLISHMENT PHONE NO.: _____ **EMAIL ADDRESS:** _____

TYPE OF FACILITY: (Check One)

- | | | |
|---|--|---|
| <input type="checkbox"/> Restaurant | <input type="checkbox"/> Concession Stand / Mobile Establishment | <input type="checkbox"/> Warehouse |
| <input type="checkbox"/> Café / Snack Bar | <input type="checkbox"/> Convenience Store / Market | <input type="checkbox"/> Temporary Vendor |
| <input type="checkbox"/> Bar (See below) | <input type="checkbox"/> Staff Restaurant / Canteen | |
| <input type="checkbox"/> Current Liquor License Available | <input type="checkbox"/> Catering | |

Brief description of type of operation and foods to be served/ sold: _____

Number of employees engaged in food handling: 0-5 6-15 16-20 20 or more

Number of seats: 1-49 50-149 150-249 250-349 350-499 500 or more

Hours of Operation: M _____ T _____ W _____ T _____ F _____ S _____ S _____

Please check the number of seats and type of facility applicable to your establishment.

Seating Food Establishments

No. of Seats	Cost	Check One
1 - 49	\$ 262	
50 - 149	\$ 273	
150 - 249	\$ 294	
250 - 349	\$ 315	
350 - 499	\$ 336	
500 or more	\$ 357	

Non-seating Food Establishments

Facility Type	Cost	Check One
Permanent	\$ 220	
Mobile Food	\$ 250	
Catering	\$ 263	

OWNER INFORMATION

OWNER NAME: _____

OWNER ADDRESS: _____

OWNER PHONE NO.: _____ **EMAIL ADDRESS:** _____

OWNER (check one): Seminole Tribal Member (Exempt) Seminole Tribe INC.(Exempt) Non-Seminole (See Fee Schedule)

NAME OF MANAGER: _____ **MANAGER PHONE NUMBER:** _____

SIGNATURE OF APPLICANT

DATE SIGNED

REAL ESTATE DIRECTOR

DATE SIGNED

BUILDING DIRECTOR

DATE SIGNED

COMPLETE AND SUBMIT TO THE ENVIRONMENTAL HEALTH OFFICE AT THE ABOVE ADDRESS

FOOD SERVICE LICENSE: (check one) APPROVED DISAPPROVED

ENVIRONMENTAL HEALTH PROGRAM MANAGER DATE SIGNED

AMOUNT PAID \$ _____ DATE PAID _____

Check Number: _____ Check Date: _____