



“POP-UP” FOOD SERVICE OPERATION

FACILITATOR APPLICATION

COMPLETE FACILITATOR APPLICATION MUST BE RECEIVED AT LEAST 10 DAYS PRIOR TO THE DAY OF OPENING A “POP-UP” LOCATION

Facilitator Company Name: _____ Phone Number: (____) _____

Authorized Agent’s Name and Title: _____

Authorized Agent’s Address: _____

Authorized Agent’s Phone Number: (____) _____ Email: _____

Address of “Pop-Up” Food Service Operation: _____

Does this location serve a Highly Susceptible Population such as pre-school age children, older adults or immunocompromised individuals receiving custodial care, health care, assisted living (e.g. child or adult day care center), kidney dialysis center, hospital or nursing home, or nutritional or socialization services such as a senior center?

Yes – “Pop-Up” Food services are NOT allowed to operate in a location serving a Highly Susceptible Population

No – please describe type of location (e.g., office building, apartment building, etc.) and where the “Pop-Up” food service will be operating (e.g., lobby, enclosed courtyard, etc.): _____

Are you the owner or authorized agent of the proposed location of the “Pop-Up” Food Service Operation?

Yes

No – Please provide written statement signed by the owner, or authorized agent of the building granting permission for the “Pop-Up” operation to take place.

Does the location have toilet facilities that meet ALL of the following criteria?

___ on the premises (if off-premises, toilets MUST be within 200 feet of the premises, and approved by the Health Authority)

___ located in a place such that patrons do not have to walk through the food service area to use them

___ if exit doors of toilet facilities have handles or knobs that must be used to open them, then sanitary towels must be provided; hand soap must also be provided



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Please describe the method(s) that will be used to limit, or identify patrons purchasing food at the “Pop-Up” location (*e.g., electronic ticket or other tracking method in the event of a foodborne illness for trace back purposes*):

Please select the method(s) and frequency for which the following information will be made available to the local Health Authority:

List of the approved food service establishments participating at the “Pop-Up” location; dates and times of operation for each participating food service establishment; and the menu of foods that will be offered by each food service establishment at the “Pop-Up” location:

- | | |
|---|--|
| <input type="checkbox"/> Website: _____ | <input type="checkbox"/> Faxed to local Health Authority |
| <input type="checkbox"/> Emailed directly to the local Health Authority | <input type="checkbox"/> Other: _____ |

Frequency of notification (*e.g., daily, weekly, monthly*): _____

STATEMENT: I hereby certify that the above information and any attached forms and documents are correct, and I fully understand that in accordance with DPH Chapter 511-6-1-.08(5) I am responsible for the following:

- a. To ensure that the location of the “pop-up” food service operation is not in violation with any other applicable regulations and ordinances (*e.g., fire department, zoning, etc.*)
- b. To notify the local Health Authority of a change in facilitator at this location.
- c. To ensure that only permitted food service establishments that have been pre-approved to operate at a “pop-up” location participate in the operation.

Additionally, I understand that non-compliance with the requirements listed above are violations of DPH Chapter 511-6-1, and the letter of approval for the “pop-up” food service operation may be suspended or revoked at the discretion of the local Health Authority.

Facilitator or Authorized Agent’s Signature: _____ Date: _____