



Environmental Health Department
30 Day – Temporary Food Service Establishment
 815 N. Broadway Ave. Tyler, TX 75702 Web: www.MyNetHealth.org
 Phone: 903-535-0037 Email: EnvironmentalHealth@netphd.org

**CHANGE OF OWNERSHIP REQUEST
 30 DAY TEMPORARY FIXED FOOD PERMIT**

Permits are non-transferrable from one owner to another. **Incomplete forms may be rejected.**
Temporary Food Service Permit is valid 30 days from the date of received and approved by the Environmental Health Department.

FOOD SERVICE NAME AND LOCATION

OLD BUSINESS NAME: _____
 PREVIOUS OWNER NAME: _____
 FACILITY STREET: _____
 CITY: _____ STATE: _____ ZIP: _____
 NETHEALTH PERMIT NUMBER: _____ - _____

NEW OWNER MAILING INFORMATION *REQUIRED*

NEW FACILITY NAME: _____
 NEW OWNERSHIP NAME: _____
 OWNER ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____
 PHONE: _____ EMAIL: _____

Has there been a:

- Change in Menu? Yes No
- Change of Seating? Yes No
- Change of Equipment? Yes No
- Change in Layout? Yes No

When was the previous business closed?

- Less than 30 Days PERMIT \$200.00
- 31 Days to 60 Days PENALTY \$100.00
- 61 Days to 90 Days PENALTY \$200.00
- > 90 Days

If a facility has changed ownership by more than 90 days OR a facility's menu, seating, equipment, or layout has changed; you must obtain approval by permitting inspection from a health inspector prior to operating. Failure to do so will result in citations.

Notice: By submitting this form, you attest to the accuracy of the information and that you will comply with the food code.

SIGNATURE: _____ **PRINT:** _____ **DATE:** _____

New owner may begin operation, once payment has been received PROVIDED THAT no changes have been made in the facility (i.e. menu change, equipment, seating, layout etc.). If anything is marked YES, the applicant does not qualify for this application.

PAYMENT INFORMATION

See back of form for where to submit this application.

Complete if applicable:

Date opened _____	Permit Fee	\$ 200.00
Seasonal operation:	Penalty Fee *	\$ _____
Date of opening _____		
Date of closing _____		
Seating capacity (if seating is provided) _____	Total Due	\$ _____
Square Footage: _____		

MAKE CHECKS PAYABLE TO: NET HEALTH

OFFICE USE ONLY

Application Received _____ Accepted _____ Rejected _____ Reason Rejected _____ Payment _____

CHECK NUMBER _____ CREDIT CARD _____ Cash _____ DATE FACILITY OPENED _____/_____/_____

INSPECTOR NAME (print) _____ SIGNATURE _____ DATE ____/____/____

APPEND? REVERSED PREVIOUS OWNER CHARGE? PREVIOUS OWNER OUTSTANDING BALANCE? PRIOR OWNER LAST INVOICE # _____