

Maryland Department of Health and Mental Hygiene  
 Environmental Health Bureau  
 Permits and Licenses  
 6 Saint Paul Street, Suite 1301  
 Baltimore, MD 21202-1608  
 Phone (410) 767-8444 Fax (410) 333-8931

### New Food Processing Plant Application

#### Facility Information

Facility Name:	Requested License Type:	Fee:
Physical Address:	<input type="checkbox"/> Food Manufacturing Plant	\$400
County: <input type="checkbox"/> Baltimore City	<input type="checkbox"/> Cold Food Warehouse/Distributor	\$400
Contact Name:	<input type="checkbox"/> Ambient Temp. Food Warehouse/Dist.	\$200
Title:	<input type="checkbox"/> Shellfish/Food Manufacturing Plant/ Cold food warehouse	\$400
Phone 1:	<input type="checkbox"/> Shellfish Shuck/Pack/Repack Plant	\$400
Phone 2:	<input type="checkbox"/> Shellfish Ship/Reship Plant	\$200
Email:	<input type="checkbox"/> Seasonal Shellfish Ship/Reship Plant:	\$100
Fax:	October 1 - March 31	
	<input type="checkbox"/> On Farm Processor	\$30
	<input type="checkbox"/> Three Month Seasonal	\$35
	Water Source <input type="checkbox"/> Public <input type="checkbox"/> Private.	
	Sewage Disposal <input type="checkbox"/> Public <input type="checkbox"/> Septic	

#### Owner or Business Organization Information

Firm Legal Name:	FEIN:
DBA:	
Legal Address:	Type of Ownership:
	<input type="checkbox"/> Individual <input type="checkbox"/> Co-ownership
	<input type="checkbox"/> Partnership <input type="checkbox"/> Corporation
	<input type="checkbox"/> Other:
Owner/Official Rep. Name:	Email:
Title:	
Phone 1:	Phone 2:
	Fax:

#### Mail Official Correspondence To

#### Payment (return with application)

ATTN (Name):		
Title:		
<input type="checkbox"/> Facility address above <input type="checkbox"/> Owner/Business address above	Amount Paid:	Check Number:
<input type="checkbox"/> Other Mail Address	<b>Note: Only checks or money orders are accepted.</b>	
	Date Received:	Received by:

The following information is required by Maryland Health General Code Annotated Code § 1-202 with regards to the Maryland Workers Compensation Act. I am (check one):

- Enclosing a Certificate of Insurance
- Providing the following insurance information:  
 Insurance Company \_\_\_\_\_  
 Policy/Binder Number \_\_\_\_\_
- Self insured - Maryland Workers Compensation Commission Certificate of Compliance enclosed
- Self-employed or only employ family members

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
 DHMH 4699