

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

## New Receiving, Transfer or Distribution Application

Facility Information	
Facility Name:	Requested Permit Type: <input type="checkbox"/> Grade A Milk <input type="checkbox"/> Manufacturer Grade Milk  *PLEASE PROVIDE COPY OF MOST RECENT HEALTH DEPT. INSPCTION.
Physical Address:	
County: <span style="float: right;"><input type="checkbox"/> Baltimore City</span>	
Contact Name:	
Phone 1: <span style="float: right;">Phone 2:</span>	
Fax:	Water Source <span style="float: right;"><input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Municipal</span>
Email:	Sewage Disposal <span style="float: right;"><input type="checkbox"/> Public <input type="checkbox"/> Septic</span>

Owner or Business Organization Information	
Company Name:	FEIN:
Legal Address:	Type of Ownership: <input type="checkbox"/> Individual <span style="float: right;"><input type="checkbox"/> Co-ownership</span> <input type="checkbox"/> Partnership <span style="float: right;"><input type="checkbox"/> Corporation</span> <input type="checkbox"/> Other:
Contact Name:	Email:
Phone 1: <span style="float: right;">Phone 2:</span>	Fax:

Mail Official Correspondence To	Payment (return with application)
ATTN (Person):	License Fees: <b>\$25</b>
<input type="checkbox"/> Facility address above <span style="margin-left: 20px;"><input type="checkbox"/> Owner/Business address above</span>	Amount Paid: <span style="float: right;">Check Number:</span>
<input type="checkbox"/> Other Mail Address	<b>Note: Only checks or money orders are accepted.</b>
	Date Received: <span style="float: right;">Received by:</span>

**The following information is required by Maryland Health General Code Annotated Code § 1-102 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 \_\_\_\_\_