

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 Frozen Dessert Application

Facility Information	
Facility Name:	Requested Permit Type:
Physical Address:	<input type="checkbox"/> 0-25,000 gal capacity
County: <input type="checkbox"/> Baltimore City	<input type="checkbox"/> 25,001-100,000 gal capacity
Contact Name:	<input type="checkbox"/> 100,001-250,000 gal capacity
Phone 1: Phone 2:	<input type="checkbox"/> 250,001-500,000 gal capacity
Fax:	<input type="checkbox"/> Over 500,000 gal capacity
Email:	*Please provide a copy of the most recent sanitation inspection for your facility.
	Water Source <input type="checkbox"/> Public <input type="checkbox"/> Private <input type="checkbox"/> Municipal
	Sewage Disposal <input type="checkbox"/> Public <input type="checkbox"/> Septic

Owner or Business Organization Information	
Company Name:	FEIN:
Legal Address:	Check all items that apply:
Contact Name:	<input type="checkbox"/> Ice cream/Frozen custard <input type="checkbox"/> Frozen Yogurt
Phone 1: Phone 2:	<input type="checkbox"/> Sherbet <input type="checkbox"/> Manufactured Desserts Mix
	<input type="checkbox"/> Water Ices <input type="checkbox"/> Other:
	Email:
	Fax:

Mail Official Correspondence To	Payment (return with application)
ATTN (Person):	License Fees: 0-25,000 gal capacity - \$10 25,001-100,000 gal capacity - \$50 100,001-250,000 gal capacity- \$100 250,001-500,000 gal capacity- \$150 Over 500,000 gal capacity - \$200
<input type="checkbox"/> Facility address above <input type="checkbox"/> Owner/Business address above	Amount Paid: Check Number:
<input type="checkbox"/> Other Mail Address	Note: Only checks or money orders are accepted.
	Date Received: Received by:

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 _____