Putnam County
Department of Health

Permit to Operate Application
☐ New ☐ Renewal

Facility Information

Operation Name: _____ Code: 39 -_____

Address: _____ Phone : _____

_____ Fax: _____

Town of: ☐Carmel ☐Kent ☐Patterson ☐Philipstown ☐Putnam Valley ☐Southeast

Mail To: (Please Print Clearly)

Permit Number

Facility Name: (for office use only) _____

Risk: (for office use only) ☐ High ☐Medium ☐Low **Fees $:** (P)_____(W)_____

Type of Operation: ☐ Food Service ☐ Food Service/Caterer ☐ Mobile Food/Vending Vehicle
☐ Temporary Residence ☐ Children's Camp ☐ Mobile Home Park ☐ Migrant Worker Housing
☐ Tanning ☐ Tattoo/Piercing Parlor ☐ Pool ☐ Beach ☐ State Licensed Agency

☐ Year Round ☐ Seasonal If seasonal: Expected Opening Date ___/___/___ Closing Date: ___/___/___
Days / Hours of Operation: _____

Facility Capacity: _____ ☐Seats ☐Beds ☐Sites ☐Persons ☐Swimmers ☐Tanning Beds/Booths

Permit Applicant Information: (Please Print Clearly)

Legal Operator or Operating Corporation: _____

Person in Charge: _____ _____ ____ _____
Title First M.I. Last

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ Cell Phone : (_____) _____

Other Phone: (_____)_____ Fax Number: (_____) _____

Email Address: _____

Owner (if different): _____

Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____)_____ Cell Phone : (_____)_____

Other Phone: (_____)_____ Fax Number: (_____) _____

Email Address: _____

Workers' Compensation & Disability Insurance

Submit copies of the following documentation with the application to document compliance with the Workers' Compensation Law:

A. Workers Compensation and Disability Insurance Coverage is PROVIDED to employees

Workers Compensation

☐ Form C-105.2	Certificate of Workers Compensation Insurance	or
☐ FormU-26.3	Certificate of Workers' Compensation Insurance	or
☐ Form SI-12	Certificate of Workers' Compensation Self Insurance	or
☐ GSI – 105.2	Certificate of Participation in Workers' Compensation Group Self Insurance	

AND

Disability Benefits

☐ DB-120.1	Certificate of Disability Benefits	or
☐ Form DB-155	Certificate of Disability Benefits Self Insurance	

B. Workers' Compensation and Disability Insurance coverage is NOT PROVIDED to employees

☐ Form CE-200	Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage

Return Completed Application

Please return completed application, appropriate insurance documents and **payment by certified check or money order ONLY to:**

Putnam County Department of Health
1 Geneva Road
Brewster, NY 10509
(845) 808-1390

Signature of Individual Operator or Authorized Official

Failure to completely fill out and sign this form may delay issuance of your permit to operate. Operation without a valid permit is a violation of the State Sanitary Code. False statements made on this application are punishable under the penal law.

Signature: _____Date:_____

Print Name: _____Title: _____

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For Office Use Only

Permit issuance recommended: ☐Yes ☐No Permit Effective Date: _____ Expiration Date:_____

Conditions of approval: _____

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Signature: _____ Title: _____Date: _____