LICKING COUNTY
HEALTH DEPARTMENT

Food Safety Program
Ownership Change Form

Name of Facility: _____

Facility Address: _____

Owner: _____ Owner Phone: _____

Owner Address: _____

Owner Email: _____ Owner Fax: _____

Contact Person: _____ Contact Phone: _____

Contact Person Address: _____

Contact Person Email: _____ Contact Person Fax: _____

My signature certifies that this facility has not been closed for more than twelve (12) months, and not more than 25% of the facility and equipment will be renovated and changed.

_____ _____
Applicant Signature Date

LCHD USE ONLY

REHS: Plan Review Fee: $ N/A

Date Received: Date Entered in Health Space:

Circle the options below that apply to this facility:

FSO or RFE Small or Large Commercial or Non-Commercial Seasonal: Yes or No

Risk Level: I II III IV Reason for Risk IV: _____

5/2023