

**Food Safety Program
Ownership Change Form**

Facility Name: _____ Facility Phone: _____

Facility Street Address: _____

Facility City: _____ State: _____ ZIP: _____

Facility Email: _____

Legal Business Name (License Holder): _____

License Holder Street Address: _____

License Holder City: _____ State: _____ ZIP: _____

License Holder Email: _____

Contact Person: _____ Contact Phone: _____

Contact Person Email: _____

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: _____