



Marion County
OREGON
Health & Human Services

MOBILE FOOD UNIT LICENSE APPLICATION

Mobile Unit Class:	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
Construction Type: <input type="checkbox"/> Pre-existing <input type="checkbox"/> New <input type="checkbox"/> Remodel			<input type="checkbox"/> Change of Ownership (provide a menu)	

License History: Was the establishment previously licensed in Oregon? ☐ Yes ☐ No
If yes, last year of operation: _____ County last licensed with: _____
Previous Mobile Unit Name: _____

Mobile Unit Name: _____

Mobile Unit Address: _____ ☐ Various Events

Estimated opening date? _____ Establishment Phone #: _____

Establishment email: _____

Owner Name: _____

☐ Individual ☐ Partnership ☐ Corporation/LLC

Do you own other establishments licensed by our office? ☐ Yes ☐ No

If yes, list the establishment name(s): _____

Owner/Billing Mailing Address: _____

Owner email: _____ Owner Phone: _____

Additional contact or billing information: _____

Fresh water source: ☐ City ☐ Home ☐ Private Well ☐ Local Business ☐ N/A

Provide the name, city and/or address of your water source: _____

Where will you dispose your wastewater? _____ ☐ N/A

****Provide a Wastewater Disposal Agreement**

Will your establishment also use a warehouse or commissary kitchen? ☐ Yes ☐ No

If yes: ☐ Warehouse ☐ Commissary (Note: additional license may be required)

Will seating be provided for customers? ☐ Yes ☐ No

Where will food workers have access to a restroom? _____

****Provide a Restroom Agreement Form**

Operating Days and Hours: Write the hours of operation -- OR -- <input type="checkbox"/> Unknown							
Days	Sun	Mon	Tue	Wed	Thur	Fri	Sat
Hours	to	to	to	to	to	to	to
Months of Operation:		<input type="checkbox"/> All Year -- OR -- <input type="checkbox"/> Other: _____					

All licenses issued under this Act shall be renewable on DECEMBER 31st of EACH YEAR. It is agreed that I will comply with the provisions of Chapter 624, Oregon Revised Statutes, and the Administrative Rules, Chapter 333, of the Oregon Health Authority pertaining thereto. Furthermore, I attest that the information provided on this form is accurate.

Applicant's Signature: _____ Date: _____

For Office Use			
Fee Received: \$		Date:	Receipt #:
<input type="checkbox"/> Approved <input type="checkbox"/> Not Approved		Date:	Inspected By: