

Renewal Application for a Permit to Operate  
Niagara County Health Department

Facility Information (Please modify only if information has changed.)

Facility x Code x

Address x Phone ( ) -  
x

Location City/Town/Village: County NIAGARA

Mail To

X X

X

Permitted Operation x(Childrens Camp)

Event \_\_\_\_\_ Fee Exempt No

In Operation:  Year-Round  Seasonal Expected Opening Date \_\_\_\_\_ Expected Closing Date \_\_\_\_\_  
Month/Day Month/Day

Days/Hours of Operation: Please enter hours of operation Capacity \_\_\_\_\_  
Units ? \_\_\_\_\_

Permit Number x Permit Expiration Date \_\_\_\_\_ Total Fee Due \$ .00

Operations Regulated by this Permit

Operation Name	Operation Type	Category	Status of Operation
<u>x</u>	<u>Children's Camp</u>	<u>Day Camp</u>	<u>PRIMARY Active</u>

Owner/Operator Information(Please modify only if information has changed.)

Permit Applicant Information

Legal Operator or Operating Corporation x x

Person in charge x x  
First M.I. Last

Address x

City, State, Zip x

Phone ( ) - Fax ( ) -

E-mail Address \_\_\_\_\_

SSN or EIN Number \_\_\_\_\_  
 SSN  EIN Number - -

Owner/Permit Applicant Information

Owner x x

Address x

City x x

Phone ( ) - Fax ( ) -

E-mail Address \_\_\_\_\_

SSN or EIN Number \_\_\_\_\_  
 SSN  EIN Number - -

FOR OFFICE USE ONLY

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Workers' Compensation and Disability Insurance (Enter current information)

Workers' Compensation		
Policy Carrier	_____	
Policy No	_____	Exp. Date _____

Disability		
Policy Carrier	_____	
Policy No	_____	Exp. Date _____

Form C10521 Issued on \_\_\_\_\_ Exp Date \_\_\_\_\_

Return Completed Application

Please return completed application to: Niagara County Department of Health  
Environmental Health Division  
5467 Upper Mountain Road Suite 100  
Lockport NY 140941894  
(716) 439 - 7444

Signature of Individual Operator or Authorized Official (Entire section must be completed by all applicants.)

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.

Signature \_\_\_\_\_  
Print Name \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

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Permit issuance recommended?  Yes  No Permit Effective Date \_\_\_\_\_ Permit Expiration Date \_\_\_\_\_

Conditions of approval \_\_\_\_\_

Signature \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_