

Date Rcvd: _____
Ck #: _____ / Cash
Receipt #: _____
Mail / Pick-up



Permit # \_\_\_\_\_

Permit Fee \$ \_\_\_\_\_

**TOWN OF SEABROOK HEALTH DEPARTMENT**

99 Lafayette Road Seabrook, NH 03874

(603) 474-3871

**APPLICATION FOR ANNUAL HEALTH PERMIT**

Application must be in ink and legible

Name of Establishment: \_\_\_\_\_

Establishment Owner: \_\_\_\_\_ Tele #: \_\_\_\_\_

Establishment Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Building Owner (If different): \_\_\_\_\_ Tele #: \_\_\_\_\_

Address: \_\_\_\_\_

**Type of License:** New: \_\_\_\_\_ Renewal: \_\_\_\_\_ Previous License #: \_\_\_\_\_

**Type of Establishment:**

Mobile Vendor \_\_\_\_\_ Hair/Nail Salon \_\_\_\_\_ Convenience Store \_\_\_\_\_

Hotel/Motel \_\_\_\_\_ Restaurant \_\_\_\_\_ Supermarket \_\_\_\_\_

Other Food Services (Please List): \_\_\_\_\_

**Fee Schedule-** (Please check applicable category)

**Restaurants:**

Seating Capacity: \_\_\_\_\_

\_\_\_ 150+ (\$150)

\_\_\_ 100-149 (\$100)

\_\_\_ 25-99 (\$75)

\_\_\_ 0-24 (\$50)

\_\_\_ **Mobile Vendors \$50**

**Hotel/Motel & Supermarkets:**

Square Footage: \_\_\_\_\_

\_\_\_ Less than 10,000 sq ft (\$50)

\_\_\_ 10,000+ (\$50 + .01 per sq ft over 10,000)

\_\_\_ **Convenience Stores \$50**

\_\_\_ **Hair/Nail Salon \$50**

*All Fees must be paid prior to Inspection. Please make checks payable to the Town of Seabrook. All businesses require a business license from the Town of Seabrook. Health Permits expire every year on December 31<sup>st</sup>.*

I hereby certify that all the information presented is true and accurate.

**Signature of Applicant/Agent:** \_\_\_\_\_ **Date:** \_\_\_\_\_