

BRIDGEWATER TOWNSHIP HEALTH DIVISION
100 COMMONS WAY
BRIDGEWATER, NJ 08807
908-725-6300 ext.5205

TEMPORARY FOOD EVENT SPONSOR APPLICATION

A Sponsor application and one registration application for each food vendor must be submitted with any required fees prior to the event. All applicable fees will be waived for events sponsored by a Government Agency, Non-Profit or House of Worship.

SPONSOR INFORMATION

Name of Sponsor _____

Name of Applicant _____

Complete Mailing Address of Sponsor _____

Business Telephone _____ Cellular Telephone _____

E-mail address _____

Website address _____

Event Name _____

Date(s)/Time/Rain Date of Event _____

Event Street Address _____

Name of Onsite Event Coordinator _____

Cell Phone # of Onsite Event Coordinator _____

Set-Up Date & Time _____

Number of Food Vendors Selling or Giving Away Food:

_____ # of Food Booths/Stand _____ # of Mobile Food Facilities (Trucks, Trailers)

Is electrical service provided for mobile food facilities and/or equipment at food booths?

Yes No

Water Supply

Location of potable water _____

Maximum distance from a temporary food booth to the water supply _____ ft.

Trash/Recyclable Containers

Containers provided by sponsor: _____Yes _____No

Is there a central refuse collection site: _____Yes _____No

Toilet/Handwash Facilities

Number of toilet facilities: Fixed_____ Portable (with water, soap and hand towels) _____

Event Type

Indoor____ Outdoor____ Other____

The event coordinator shall ensure that all food vendors register and are approved by the Bridgewater Health Division to participate in the temporary event.

AFFIDAVIT

The information contained in this application is accurate to the best of my knowledge. I agree in the event this license is granted to abide and comply with the applicable laws, ordinances and regulations of the State of New Jersey and the Township of Bridgewater, with full knowledge that failure to comply may result in the revocation of this license, or the imposition of such other penalties provided by law.

Event Coordinator’s Signature _____

Date_____

For Office Use Only:

Approved_____

Denied_____ Comments_____

REHS/Health
Spechialist_____

Notes:

