Wicomico County Health Department
108 East Main Street • Salisbury, Maryland 21801
Matthew McConaughey, MPH, Health Officer

Environmental Health www.wicomicohealth.org **(410) 546-4446**

Mobile Reciprocity License Application

Application is hereby made to operate a food service facility in accordance with the Code of Maryland Regulations (COMAR) 10.15.03 and all applicable state and local laws.

Application Fee: $200

The following documentation must be provided with this application in order to qualify:

- Maryland "County of Origin" issued Food Service Facility License
- Commissary or Base of Operation Authorization Form (Commissary or Base must be within 90 miles)
- Menu and approved HACCP plan
- Copy of Vehicle Registration and photo of mobile unit (showing entire exterior of vehicle)
- $200 Mobile Reciprocity License Fee payable to the Wicomico County Health Department

Facility Name: _____

Name of **Owner**: _____

Owner Mailing Address: _____

Phone: _____ Fax: _____ e-mail: _____

Contact Person (if different than owner): _____

Contact person Mailing Address: _____

Phone: _____ Fax: _____ e-mail: _____

Vehicle License Plate Tag# _____

Dates of Operation: From _____ to_____ or Year Round

Applicant Signature: _____ Date: _____

Applicant printed name: _____

_____

Office Use Only: **Establishment ID**: _____

Date License Issued: _____ EHSpecialist: _____

Date: _____ Fee:_____ ❑ Cash ❑ Credit ❑ Check #_____ Receipt#_____

Priority Assessment: High Moderate Low

Public Health
Prevent. Promote. Protect.
Wicomico County Health Department

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Accredited Health Department
PHAB
Advancing Public Health Performance
Public Health Accreditation Board

STATEMENT OF WORKERS' COMPENSATION INSURANCE

Maryland Code Annotated, HealthGeneral Article, §1202 requires that an employer must file with the issuing authority: (1) a certificate of compliance with the Maryland Workers Compensation Act; or (2) a workers' compensation insurance policy or binder number before any license or permit is issued.

Please circle the number of the option below which best applies to you, provide the requested information, sign, date the form, and return it with the attached application.

1. I have worker's compensation insurance.

   Insurance Company _____

   Policy or Binder Number _____

2. I do not have any c*overed employees* as defined by Maryland Code Annotated, Labor and Employment Article §9-202, and therefore, am exempt from having workers' compensation insurance.

3. I am self-insured. Approval of self-insurance has been received from the Worker's Compensation Commission. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE).

_____ _____
Signature Title

_____
Printed Name of Attester

_____ _____
Business Name Date

410-749-1244 • FAX 410-543-6975 • TDD 410-543-6952
DEPARTMENT OF HEALTH AND MENTAL HYGIENE • 1-800-4MD-DHMH
AFFIRMATIVE ACTION AND EQUAL OPPORTUNITY EMPLOYER AND PROVIDER