

## FOOD SERVICE OPERATION FORM

Legal Business Name: \_\_\_\_\_

Facility Name: \_\_\_\_\_

**Section A: Operation Description**

1. Operation description:

a) Date food service operation began (mo/yr): \_\_\_\_\_

b) Size of food service operation (square feet): \_\_\_\_\_ (include food preparation and consumption)

c) Number of seats in dining room: \_\_\_\_\_

d) Type of service:  Take out/delivery only  Dine-in only  Both

e) Average number of employees: \_\_\_\_\_

f) Expected daily average number of meals: \_\_\_\_\_

g) Do you wash plates?  Yes  Noh) Days of Operation:  Sunday  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  
(check all that apply)

i) Hours of operation: \_\_\_\_\_

j) Best time for inside inspections: \_\_\_\_\_

**Section B: Facility Description**

1. Type of food service facility: (check all that apply)

<input type="checkbox"/> Bakery	<input type="checkbox"/> Bar (drinks only)	<input type="checkbox"/> Cafeteria	<input type="checkbox"/> Catering
<input type="checkbox"/> Coffee Shop	<input type="checkbox"/> Commissary	<input type="checkbox"/> Deli	<input type="checkbox"/> Fast Food
<input type="checkbox"/> Food Packager	<input type="checkbox"/> Full Service Dine-in	<input type="checkbox"/> Ice Cream Shop	<input type="checkbox"/> Meat Processor
<input type="checkbox"/> Prepared Food Assembly	<input type="checkbox"/> Take Out	<input type="checkbox"/> Other _____	

2. Location of food service facility: (check all that apply)

<input type="checkbox"/> Club / Organization	<input type="checkbox"/> Company / Office Building	<input type="checkbox"/> Hospital	<input type="checkbox"/> Hotel / Motel
<input type="checkbox"/> Mall / Food Court	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Prison	<input type="checkbox"/> Religious Institution
<input type="checkbox"/> School	<input type="checkbox"/> Stadium / Amusement Park	<input type="checkbox"/> Stand-alone Restaurant	<input type="checkbox"/> Supermarket
<input type="checkbox"/> Strip Mall (attached)	<input type="checkbox"/> Other _____		

3. Major equipment used for food preparation at this facility: (check all that apply or submit a copy of your company's equipment schedule)

<input type="checkbox"/> Buffalo Chopper	<input type="checkbox"/> Charbroiler	<input type="checkbox"/> Deep Fat Fryer	<input type="checkbox"/> Flat Top Range
<input type="checkbox"/> Griddle	<input type="checkbox"/> Grill	<input type="checkbox"/> Jacketed Kettle	<input type="checkbox"/> Oven
<input type="checkbox"/> Rotisserie	<input type="checkbox"/> Smoker Stove	<input type="checkbox"/> Tilt Kettle	<input type="checkbox"/> Warming Drawer
<input type="checkbox"/> Wok	<input type="checkbox"/> Other _____		

4. Fixtures in the bar, kitchen, cleanup, and food prep areas: (check all that apply)

<input type="checkbox"/> 3-Compartment Sink	<input type="checkbox"/> Bar Sink	<input type="checkbox"/> Dishwasher	<input type="checkbox"/> Disposer
<input type="checkbox"/> Floor Drain	<input type="checkbox"/> Flushing Rim Sink	<input type="checkbox"/> Flush Valve Sink	<input type="checkbox"/> Hand Sink
<input type="checkbox"/> Mop Sink	<input type="checkbox"/> Pre-Rinse Sink	<input type="checkbox"/> Prep Sink	<input type="checkbox"/> Service Sink
<input type="checkbox"/> Other _____			

**Section C: Waste Management**

**Trash / Solid Waste Disposal**

1. Type of collection receptacle(s) (check all that apply):  
 Cans       Dumpster       Compactor       Other \_\_\_\_\_
2. Location of collection receptacle(s): \_\_\_\_\_
3. Frequency of pick-up: \_\_\_\_\_
4. Trash removal service (business name and address): \_\_\_\_\_  
 \_\_\_\_\_
5. Contact name and telephone number: \_\_\_\_\_
6. Do you share the use of the trash receptacle(s)?  Yes     No

**Cooking Oil Disposal**

Type	Buckets/Drums	Dumpster	Collection System	None
Frequency of Pick-up				

**Wastewater Grease Control**

7. Does your company have a grease trap(s) or interceptor(s)?  Yes       No
8. Location of grease trap(s)/interceptor(s):  Inside     Outside
9. Size (capacity) of grease trap(s)/interceptor(s): \_\_\_\_\_
10. How often do you clean the grease control device?  
 Daily                       Weekly                       Biweekly                       Monthly  
 Bimonthly                       Quarterly                       Semiannually                       Annually  
 As Needed                       Other \_\_\_\_\_

Type	Inside Under Sink Trap	Outdoor Interceptor		
Size				
Frequency of Cleaning				
Who Cleans?				

11. Grease trap service contractor (business name and address): \_\_\_\_\_  
 \_\_\_\_\_
12. Contact name and telephone number: \_\_\_\_\_  
 \_\_\_\_\_
13. Briefly describe storage areas for chemicals and liquid materials such as boiler treatment, cooking oil, gasoline, oil, paint, sanitizers, as well as any spill protection devices in use at the facility.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
14. Is there a privately owned manhole for collecting a wastewater sample?  Yes     No  
 If yes, attach plot plan showing the location of the manhole at the facility.

**Certification**

"I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fines and imprisonment for knowing violations."

\_\_\_\_\_  
Signature of Duly Authorized Representative

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date