TEXAS Health and Human Services | Texas Department of State Health Services

WRHSEOP 2402 FO

BUDGET ZZ104
FUND 183
LICENSE NUMBER:

INTERNAL USE ONLY

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
BUSINESS FILING AND VERIFICATION SECTION

WAREHOUSE OPERATOR LICENSE APPLICATION MINOR AMENDMENT CHANGE

Health and Safety Code, Chapter 431
Texas Administrative Code, Chapter 229

NOT FOR CHANGE OF OWNERSHIP

FACILITY INFORMATION

License number and expiration date: _____
Name Under Which Business is Conducted (DBA): _____
Physical Street Address: _____
City, State, Zip Code: _____ **County** _____
Telephone # at address: (_____) _____
Business Hours of operation: _____m. to _____m.

WEBSITE/INTERNET ADDRESS http://www._____

Must check **yes** or **no** for each question:

Does this warehouse store produce only? ☐ **Yes** ☐ **No**

Does this warehouse store **seafood products** (fresh, non-frozen, dried)? ☐ **Yes** ☐ **No**

RESPONSIBLE INDIVIDUAL IN CHARGE AT PHYSICAL ADDRESS

_____ _____

Name & Title Residence Address

PURPOSE OF THIS APPLICATION

Mark appropriate box to indicate purpose of application and/or any change in status of firm.

☐ **Amended** Previous Location:_____
Previous Name: _____
Effective Date for changes: _____
Other: _____

MAILING INFORMATION

(The license and/or courtesy renewal notice will be sent to the following):

Mailing Name:_____

Mailing Address:_____

City, State, Zip Code:_____

Name of Application Preparer (Contact Person):_____

Telephone Number of Application Preparer (Contact Person): _____

E-mail Address of Application Preparer:_____

LICENSE HOLDER INFORMATION

Please enter the 11-digit State Tax Payer's Identification number on file with the Texas Comptroller of Public Accounts. Also your 9-digit Federal Employee Identification Number (EIN). Sole proprietors may enter their social security number.

Tax Payer # **EIN #**

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Social Security #

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Complete <u>ONE</u> box on this page that relates to the type of ownership of your business.

☐ **Sole Owner/Proprietorship**

Name of Sole Owner:

_____

Name Residence Address

☐ **Partnership** ☐ **LP** ☐ **LLP** ☐ **LTD**

Name of Partnership: _____

Partnership Address:

_____/_____/_____/_____

ADDRESS CITY ST ZIP

Partner Name: _____

Residence Address

Partner Name: _____

Residence Address

Partner Name: _____

Residence Address

☐ **Association** ☐ **State Agency**

Name of Association / State Agency: _____

Address:_____/_____/_____/_____

ADDRESS CITY ST ZIP

Name: _____

Residence Address

Name:_____

Residence Address

☐ **Corporation** ☐ **LLC**

Name of Corporation: _____

Corporation Address: _____/_____/_____/_____

ADDRESS CITY ST ZIP

President Name: _____

Residence Address

Officer's Name: _____

Residence Address

Officer's Name: _____

Residence Address

Name of Registered Agent: _____

Residence Address

FEE SCHEDULE FOR MINOR AMENDMENT CHANGE

The **non-refundable fee** is based on the maximum amount of square feet dedicated to food storage during the licensing period. (biennial).

(Table 2 fees based on SQUARE FOOTAGE)

Please check one below	SQUARE FEET OF FOOD STORAGE	FEE DUE
	0 sq ft - 6,000 sq ft	$ 175.00
	6,001 sq ft - 24,000 sq ft	$ 350.00
	24,001 sq ft - 75,000 sq ft	$ 525.00
	75,001 sq ft - 250,000 sq ft	$ 700.00
	250,001 sq ft - or more	$1,000.00

MAILING AND PAYMENT INFORMATION

Return the completed application and **non-refundable** fee to:
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
Cash Receipts Branch
MC 2003
PO Box 12008, Austin, Texas 78711

Make your check or money order payable to:
Texas Department of State Health Services

DO NOT SEND CASH OR A TEMPORARY CHECK
FEES ARE NON-REFUNDABLE

IMPORTANT INFORMATION

Normal processing time is four to six weeks.

A license will not be issued unless the application is complete.

Initial licenses will expire two years from date of payment receipt by the Department.

Any returned checks received after the expiration date will be assessed the $100.00 late fee.

Fees are non-refundable.

CONTACT AND CORRESPONDENCE INFORMATION

You may contact our office at: (512) 834-6626 or foodslicensinggroup@dshs.texas.gov
You can visit our website at www.dshs.texas.gov or
You can send correspondence to:
Texas Department of State Health Services
BF&VS, Food & Drug Business Filing and Verification Unit,
MC 2835
PO Box 149347
Austin, Texas 78714-9347

PRIVACY NOTIFICATION

With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. You may visit our website www.dshs.texas.gov for more information on the Privacy Notification (Reference: Government Code, Section 552.021, 552.023 and 559.004).

VERIFICATION

I swear or affirm that all information in this application is true and correct. I further certify by signature hereon, that I am authorized to execute this document on behalf of the corporation and am eligible to receive a license. If signing this as owner of a sole proprietorship, I am not delinquent in the payment of any child support owed under Chapter 232, Family Code. If signing as a sole proprietor, I certify I have filed the Assumed Name Certificate in appropriate counties pursuant to Business and Commerce Code, Chapter 36. I further certify that I have read and understand Chapter 431 of the Health & Safety Code, the applicable provisions of 25 Texas Administrative Code, Chapters 229, and agree to abide by them.

_____ ☐ OWNER _____

Signature ☐ PARTNER Date

☐ PRESIDENT

_____ ☐ CORPORATE DESIGNEE / AGENT

Printed Name & Title