

2026 HEALTH LICENSE APPLICATION – DUE 11/30/2025



CUSTOMER NUMBER (Located on top left of invoice):

Establishment Name: _____

Street Address: _____

City: **Bethlehem** State: **PA** Zip: _____

Facility Phone Number: _____

Facility Email Address: _____

Contact Person: _____ Contact Phone Number: _____

Emergency Contact: _____ Emergency Phone Number: _____

Registered Owner of Establishment: _____

If Owner Name listed above is a corporation/firm/LLC, please complete the information below listing the person holding primary responsibility for the establishment.

Responsible Party Name: _____

Responsible Party Street Address: _____

City: _____ State: _____ Zip: _____

Responsible Party Email Address: _____

Food Manager Certification Information

Certified Food Manager on SITE: _____

Certification Program (Ex: ServeSafe, 360° Training, Prometrics, etc.): _____

Certificate Number and Expiration Date: _____

***PLEASE ATTACH A COPY OF THE CERTIFICATE**

Additional Certified Individuals:

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****COMMISSARY INFORMATION (**If applicable)**

If your Facility serves as a commissary kitchen, please list the names of all businesses operating from your facility.

If your business operates from a commissary kitchen, please provide the name and address of the commissary facility and submit a copy of the commissary agreement.

Name: _____ Address: _____

Hours of Operation:

- | | |
|--|---|
| <input type="checkbox"/> Sunday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Monday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Tuesday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Wednesday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Thursday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Friday: _____ to _____ | <input type="checkbox"/> Closed All Day |
| <input type="checkbox"/> Saturday: _____ to _____ | <input type="checkbox"/> Closed All Day |

Name of Garbage Hauler and Frequency of Pick-up: _____

I hereby certify that all information listed above is complete and accurate to the best of my knowledge. I further understand that failure to complete any portion of this application and/or failure to submit the appropriate fee, or Food Employee Certification will result in the City of Bethlehem Health Bureau to consider this application incomplete. Failure to make necessary changes by expiration dates will result in late fees being assessed.

Name of Responsible Party: _____ Signature of Responsible Party: _____ Position: _____ Date: _____

SUBMITTAL CHECKLIST : (Please make sure the following are included prior to submitting)

- | | |
|---|--|
| <input type="checkbox"/> COMPLETED Application | <input type="checkbox"/> Check/Money Order payable to “City of Bethlehem” or submit online payment |
| <input type="checkbox"/> Copy of Certified Food Manager certificate | <input type="checkbox"/> Past Due Fees/Invoice (if applicable) |
| <input type="checkbox"/> Copy of Attached Invoice | |