



MESSAGE ESTABLISHMENT APPLICATION FORM

Environmental Public Health Division
 515 S. Liberty Street
 P. O. Box 1019
 Independence, MO 64051-0519
 Phone: (816) 325-7803 Fax: (816) 325-7074
 www.independencemo.org/health

This form must be completed for all new and change of ownership facilities and for any changes to facility information. **If the information on this application changes, this department is to be notified. Picture identification is required to process application (i.e. driver's license, passport, etc.)** PLEASE PRINT LEGIBLY.

Facility Name: (as it will be shown on permit)	Phone: () _____ Fax: () _____ Cell: () _____
Facility Address:	Email: _____ Website: _____

Anticipated Opening Date:	Ownership Legal Type: <input type="checkbox"/> LLC <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership Date of Incorporation or Partnership _____ Location: _____
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OWNERSHIP INFORMATION

Owner's Name:	Phone: () _____ Cell: () _____ Fax: () _____ Email: _____ Website: _____
Owner's Address: _____ City, State: _____ Zip: _____	Date of Birth: _____ SS#: _____ DL #: _____

CO-OWNER/PARTNER INFORMATION

Owner's Name:	Phone: () _____ Cell: () _____ Fax: () _____ Email: _____
Owner's Address: _____ City, State: _____ Zip: _____	Date of Birth: _____ SS#: _____ DL #: _____

EMPLOYEE INFORMATION

Names of managing officers, employees:

Name	Address	Date of Birth

A HEALTH CERTIFICATE ISSUED BY A LICENSED MEDICAL PRACTITIONER IS REQUIRED FOR EACH EMPLOYEE LISTED (use back of form if needed)

For Office use only: Date: _____ Approved Not Approved Permit# _____

Signature _____

Title _____

Printed Name _____

Date _____