

Grease Management Permit Program



SECTION A – GENERAL INFORMATION

1. Facility Name: _____

2. Facility Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____ Fax Number: _____
Website: _____

3. Business Mailing Address: (if different from 2. above)
Address: _____
City: _____ State: _____ Zip: _____

4. Property Owner (if different than facility):
Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone number: _____ E-mail Address: _____

5. Designated facility contact:
Name: _____
Title: _____
Phone number: _____ E-mail Address: _____

SECTION B – OPERATIONS

1. Please choose the description(s) that best fits your facility.

- | | |
|--|--|
| <input type="checkbox"/> Fast Food Restaurant | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Full-Service Restaurant | <input type="checkbox"/> Hotel/Motel |
| <input type="checkbox"/> Drive-Through (only) Restaurant | <input type="checkbox"/> School |
| <input type="checkbox"/> Seasonal Restaurant | <input type="checkbox"/> Club/Organization |
| <input type="checkbox"/> Coffee Shop | <input type="checkbox"/> Company/Office Building |
| <input type="checkbox"/> Bakery | <input type="checkbox"/> Ice Cream Shop |
| <input type="checkbox"/> Supermarket | <input type="checkbox"/> Hospital |
| <input type="checkbox"/> Religious Institution | <input type="checkbox"/> Catering |
| <input type="checkbox"/> Other _____ | |

2. What is the seating capacity at your facility? _____

3. What are the days and hours of operation? _____

