



Mohegan
Tribe

HEALTH DEPARTMENT

13 Crow Hill Road
Uncasville, CT 06382

Telephone: (860) 862-6135 Fax: (860) 862-6189 Email: klavigne@moheganmail.com

TEMPORARY FOOD SERVICE APPLICATION

Application must be received no later than 10 business days prior to the event.

This application must be filled out for any food/beverage offered for consumption on the Mohegan Tribe Reservation.

All fields are required to be completed.

REQUIRED DOCUMENTATION:

- **COPY OF AN ACCREDITED FOOD SAFETY MANAGER TRAINING CERTIFICATE**

Business Name: (to appear on permit) _____

Business Address: _____ Phone: _____

Event Name: _____ Date/Time: _____

Location of the Event on the Reservation: _____

Please PRINT name, email address and phone number of primary contact person for food safety at event, if different then above.

Name

Phone/Cell Phone

E-mail Address

1. List all items on the proposed menu. (Attach menu if necessary)

2. Where will food and ingredients be purchased from?

3. How will food items be cooked?

4. Will food be cooked ahead and cooled, prepared and/or stored? If yes, where?
5. How will food items be kept cold (at or below 41°F) and/or hot food items be kept hot (at or above 135 °F) in transport and at event?
6. Describe the type of hand washing to be used, if required.
(Sanitizer is not a substitute for hand washing)
7. How will food equipment and utensils be cleaned and sanitized?

Businesses wishing to operate on the Mohegan Reservation are not allowed without prior approval of the Mohegan Tribe Health Department.

The Mohegan Tribe Health Department enforces the 2017 FDA Model Food Code. Anyone utilizing a Mohegan Sun kitchen is expected to adhere to all provisions of this Code and may be subject to inspections and/or enforcement actions if necessary, including disposal of food in temperature danger zone.

I have read the enclosed information and understand that the Mohegan Tribe Health Department may inspect my booth and may not issue a permit or suspend my permit to operate at any time if food safety standards are not met.

Applicant Signature: _____ Date: _____

Comments: _____

REVIEWED/APPROVED: _____
 Director of Health or Registered Sanitarian