V.I. DEPARTMENT OF HEALTH
DIVISION OF ENVIRONMENTAL HEALTH

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Certification of Permit Fee Payment
Amount Paid _____
Date _____
Clerk Initial _____

Official Stamp

APPLICATION FOR A HEALTH PERMIT

Permit Type:
ANNUAL ☐ TEMPORARY ☐ EXPIRATION DATE: _____

(The area above this line is for official use only)

(PLEASE PRINT OR TYPE)

DATE: _____

TO: The Commissioner of Health

I hereby apply for a Health Permit to operate a _____
(Type of Establishment)

In accordance with the requirements of Title 19 of the Virgin Islands Code and Virgin Islands Rules and Regulations, I hereby provide you with the following information:

Name of Establishment: _____

Seating Capacity: _____

Address of Establishment: _____
(Street No.) (Estate or Quarter) (Island)

Owner's Name: _____
(If Corporation, give Corporate name and the name of a Corporate officer and Title)

Owner's Home Address: _____
(Street No.) (Estate or Quarter) (Island)

Owner's Mailing Address: _____
(Street Address or P.O. Box) (Island) (Zip Code)

Contact Information: _____
(Business Phone) (Home Phone)

_____
(Cell Phone) (Fax Number) (E-mail Address)

I understand that the operation of the above establishment must be in accordance with the requirements of Title 19 of the Virgin Islands Code and Rules and Regulations, and that failure to comply with the requirements is cause for the suspension or revocation of a PERMIT issued as a result of this application.

I attest that all of the information set forth above is true and complete.

_____ _____
(Signature of Owner or Authorized Representative) (Date)

(Revised 1/08) Original – Dept. Copy Carbon Copy – Vendor's Copy

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