ANGELINA COUNTY & CITIES
HEALTH DISTRICT

2024-2025 HEALTH PERMIT RENEWAL

ESTABLISHMENT INFORMATION

Establishment Name:		
Establishment Physical Address:		
City:	State:	Zip:
Establishment Phone:		
Establishment Email:		
Water Company:		

OWNER INFORMATION

Legal Owner Type: ☐ Corporation ☐ Individual ☐ Partnership ☐ Other: _____

Owner Name:		
Owner Mailing Address:		
Owner City:	State:	Zip:
Owner Phone:		
Owner Email:		
Billing Email:		

Payments are due by October 15, 2024. A late fee of $100 will be applied to any payments received after this date. Acceptable forms of payment include cash, check, or money order.

AGREEMENT

I HEREBY SWEAR OR AFFIRM THAT ALL INFORMATION PROVIDED IN THIS APPLICATION IS TRUE AND CORRECT. I FURTHER CERTIFY BY MY SIGNATURE THAT I AM AUTHORIZED TO EXECUTE THIS DOCUMENT ON BEHALF OF THE CORPORATION AND AM ELIGIBLE TO RECEIVE A LICENSE. I ALSO CERTIFY THAT I HAVE READ AND UNDERSTAND CHAPTER 437 OF THE HEALTH & SAFETY CODE, AS WELL AS THE APPLICABLE PROVISIONS OF 25 TEXAS ADMINISTRATIVE CODE, CHAPTERS 226, 228, AND 229, AND I AGREE TO ABIDE BY THEM.

_____ _____ _____

Applicant's Signature *Applicant's Name (Printed)* *Date*