TOURIST ACCOMMODATION (HOTEL) PERMIT APPLICATION

Division of Environmental Health
Department of Restaurants & Hotels
445 Winn Way, Suite 320
Decatur, GA 30031
Phone: (404) 508-7900 Fax: (404)508-7979
www.dekalbpublichealth.com

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 or application addendum changes this department is to be notified.** (PRINT IN CAPITAL LETTERS)

Facility Name: (as it will show on permit)		Phone: ( ) _____ Fax : ( ) _____
Facility Address:	City: _____ Zip Code: _____	E-mail: _____ Website: _____
Anticipated Opening Date:	Number of Units (Rooms) :	

HOTEL INFORMATION Check all that apply:
☐ Hotel/Motel **Food Service:** ☐ None ☐ Continental Breakfast ☐ Permitted Establishment
☐ Bed & Breakfast
☐ Campground

OWNERSHIP INFORMATION

Ownership Legal Type: ☐ Sole Owner ☐ Partnership ☐ Corporation

Owner's Name:		Owner's Home Phone: ( ) _____ Owner's Cell Phone: ( ) _____
Owner's Address:	City: _____ State: _____ Zip Code: _____	E-mail: _____ Fax Number: ( ) _____

BILLING INFORMATION (for INVOICES) *same as facility* ☐ **or:**

Bill to Name: Bill to Address:	City: _____ State: _____ Zip Code: _____	Phone: ( ) _____ E-mail: _____ Fax Number: ( ) _____

AUTHORIZED AGENT INFORMATION: Authorized Agent means the person to whom the Business Owner has delegated authority for the overall management of the Tourist Accommodation. No other agent's signature will be accepted.

Agent's Name:	Home Phone: ( ) _____ Cell Phone: ( ) _____
Address	City: _____ Zip Code: _____

The undersigned hereby applies for a permit to operate a Tourist Accommodation pursuant to the Georgia Health Code, Title 31-28-1, Georgia Laws 1964, p. 499 et seq., and hereby certifies that he has received a copy of the Rules and Regulations of the Georgia Department of Human Resources for Tourist Accommodations, Chapter 290-5-18.. The undersigned hereby attests to the accuracy of the information provided in this application, and affirms that the undersigned will comply with this chapter, and allow the Health Authority access to the establishment**. IT IS UNLAWFUL TO PROVIDE FALSE INFORMATION ON THIS DOCUMENT.**

Signature:	Date:
Signature:	Date:
Signature:	Date:

FEES ARE NOT TRANSFERABLE OR REFUNDABLE

Office Use Only	
Establishment #: _____ Inspector ID #: _____	a) ☐ Facility Name change: Old name: _____ b) ☐ Billing Address change ☐ Owner Address change c) ☐ Corporation name change d) ☐ Facility closed (voluntary) Effective Date _____