FOOD SERVICE ESTABLISHMENTS SURVEY

Facility Information:

Name: ______________________________

Street Address: ______________________________

Mailing Address (if different): ______________________________

Facility Contact's Name: ____________________ Phone: ____________

Email: ______________________________

Owner's Information:

Name: ____________________ Phone: ____________

Email: ______________________________

Property Owner (if different than facility owner):

Name: ______________________________

Address: ______________________________

Email: ____________________ Phone: ____________

Facility Operational Characteristics:

1. Choose one description that best describes your facility (check one):

☐ Fast Food Restaurant	☐ Full-Service Restaurant	☐ Nursing Home
☐ Drive through (only)	☐ Concession Stand	☐ Hotel/Motel
☐ Coffee Shop	☐ Bakery	☐ Supermarket
☐ Religious Institution	☐ School/College	☐ Club/Organization
☐ Company/Office Building	☐ Ice Cream Shop	☐ Hospital
☐ Caterer	☐ Convenience Store	☐ Bar/Lounge
☐ Meat Market	☐ Produce Market	☐ Cafeteria

☐ Other (specify): ______________________________

2. Describe the type of food served: (attach a copy of the menu)

____

____

3. Service Method (check applicable):

☐ Washable Plates ☐ Disposable Plates/Baskets ☐ Carry-Out

4. Seating Capacity of facility: ____________

5. Estimated Average Meals per Day: ____________

6. Indicate each item that is currently installed or will be installed and the quantity of each:

☐ Pre-Rinse/Spray Sink	________	☐ Hand Sink	________
☐ Three-Bay Sink	________	☐ Floor Drains	________
☐ Two-Bay Sink	________	☐ Oven	________
☐ Single-Bay Sink	________	☐ Grill	________
☐ Mop Sink	________	☐ Deep fryer	________
☐ Garbage Disposal	________	☐ Tilt Kettle/crock pot	________
☐ Dishwasher	________	☐ Wok/Cooker	________

7. Complete the hours of operation for each day that your facility will be or is open:

Monday: ____________ Tuesday: ____________ Wednesday: ____________

Thursday: ____________ Friday: ____________ Saturday: ____________

Sunday: ____________

Existing Fats, Oils, and Grease Treatment:

1. Is there currently a grease removal device at this facility? ☐ Yes ☐ No

   If yes, complete the following and attach manufacturer's specifications for all devices

   a. Make and Model: ____________________

   Capacity: ____________ Gallons or ____________ Pounds

   Type: ☐ Passive or ☐ Automatic ☐ Indoor or ☐ Outdoor

   Cleaning Frequency: ____________________

   Location: (under 3-bay sink, in basement, outside in ground, etc.)

   ____

   b. Make and Model: ____________________

   Capacity: ____________ Gallons or ____________ Pounds

   Type: ☐ Passive or ☐ Automatic ☐ Indoor or ☐ Outdoor

   Cleaning Frequency: ____________________

   Location: (under 3-bay sink, in basement, outside in ground, etc.)

   ____

2. If the indoor grease removal device (trap) is being maintained onsite, how do you dispose of the waste after cleaning the device (check one)?

   ☐ Trash ☐ Contractor Disposes of Grease ☐ Recycle

   ☐ Other: (specify): ____________________

3. If a contractor(s) cleans the indoor or outdoor grease removal device(s), please list the following:

   a. Contractor's Name: ____________________

   Address: ____________________ Phone: ____________

   b. Contractor's Name: ____________________

   Address: ____________________ Phone: ____________