



DELAWARE HEALTH AND SOCIAL SERVICES

Division of Public Health

APPLICATION FOR / RENEWAL OF A PERMIT TO OPERATE RECREATIONAL CAMPS

This application must be completed for each new recreational camp or an existing recreational camp. Return this application to the Environmental Health Field Service in the county in which the camp is located, and please make a photocopy for your records.

NEW APPLICANTS SHOULD CONTACT THE OFFICE OF ENGINEERING AT 302-741-8640. AN APPLICATION MUST BE SUBMITTED FOR EACH CAMP AT LEAST 30 DAYS PRIOR TO OPERATING CAMP. INCOMPLETE APPLICATIONS MAY BE RETURNED. PLEASE PRINT OR TYPE.

ENVIRONMENTAL HEALTH FIELD SERVICES
NEW CASTLE COUNTY HEALTH UNIT
CHOPIN BLDG
258 CHAPMAN RD., SUITE 105
NEWARK, DE 19702
302-283-7112

NAME OF CAMP: _____

LOCATION OF CAMP: _____

MAILING ADDRESS: _____

PHONE: _____

OPERATED BY: _____

(List name of individual, club, corporation, etc.)

OPENING DATE: _____ CLOSING DATE: _____

DIRECTOR: (Full name): _____ EMERGENCY PHONE #: _____

TYPE OF CAMP PERMIT REQUESTED: _____ DAY _____ PRIMITIVE
_____ HOSTEL _____ RESIDENTIAL _____ TRAVEL _____ TROOP

REQUESTED CAPACITY: _____ PERSONS AND / OR CAMPSITES: _____

DO YOU PLAN TO OPERATE IN SESSIONS: YES _____ NO _____

IF YES, NUMBER: _____ AND LENGTH OF SESSIONS: _____

NUMBER OF STAFF: _____

OVER 18: MALE _____ FEMALE _____ # UNDER 18: MALE _____ FEMALE _____

Has any member of the Staff or operation ever been convicted of a Felony or Class "A" Misdemeanor? YES ___ NO ___

If YES, identify Type of Offense, Date, Location and name of Person Convicted.

TYPE OF FACILITIES: PERMANENT BLDGS _____ TENTS _____ OTHER _____

NUMBER OF TOILET FACILITIES: MALE _____ FEMALE _____

NUMBER OF SHOWER FACILITIES: MALE _____ FEMALE _____

In accordance with State of Delaware Regulations Governing the Sanitation of Recreational Camps adopted under Title 16 Del. C. Section 122, I, the undersigned, hereby make application for permit to operate a recreational camp.

SIGNATURE _____ DATE _____

PRINTED NAME _____

OFFICIAL USE ONLY

PERMIT RECOMMENDED: ANNUAL _____ PROVISIONAL _____ CAPACITY _____

EHFS SUPERVISOR: _____ DATE: _____

HSP PLAN REVIEW ACTION: APPROVED _____ DISAPPROVED _____ DATE: _____

ADMINISTRATOR: _____ DATE: _____

PERMIT NUMBER: _____ DATE ISSUED: _____ TYPE: [] ANNUAL [] PROVISIONAL 02/07