# User Application

Date: _____

Name: _____

Phone: _____ _____ _____

Daytime Home or Emergency # Pager, Mobile, etc.

Home Address: _____

City/State/Zip: _____

SSN: _____

Business Name: _____

Business Address: _____

City/State/Zip: _____

Driver's License No. _____ (attach copy) (include employees on separate sheet)

Business Status: ☐ Pre-Venture Projected Start Date: _____

☐ New (1st Year) Start Date: _____

☐ Existing Start Date: _____

Legal Status:

☐ Sole Proprietorship

☐ Coporation (EIN _____

☐ Partnership (EIN_____

Type of Business:

☐ Specialty Food Producer

☐ Caterer

☐ Vendor

☐ Other _____

Previous Business Name and Address:

_____

_____

Previous Health Department Jurisdiction: _____

_____

_____

_____

D.E.C. Kitchen Application (Continued)

1. Denver Health & Hospitals Food Handler's Cartificate (attach copy)
   Expiration Date: _____
2. Business – Professional License
   Type: _____ Exp. Date: _____
3. Breifly describe your business/food product(s) and the products you wish to prepare at the Kitchen Incubator:

   _____

   _____

   _____

   _____

4. List ingredients needed to prepare your food product(s):
   a. _____ e. _____
   b. _____ f. _____
   c. _____ g. _____
   d. _____ h. _____
5. What type of equipment do you require to prepare your product?
   a. _____ e. _____
   b. _____ f. _____
   c. _____ g. _____
   d. _____ h. _____
6. What type of equipment do you require to package your product?
   a. _____ e. _____
   b. _____ f. _____
   c. _____ g. _____
   d. _____ h. _____
7. How will your product be shipped? _____
8. Is a written business plan available for review? (please attach) _____
   a. If not, list date business plan is to be completed _____
9. What is your target market? _____

   _____

D.E.C. Kitchen Application (Continued)

10. How do you (plan to) market your product? _____

_____

_____

11. Number of employees: Full time _____ Part time _____
12. If you are already in business, has your product proven viable: _____
    If yes, where and how is it produced? _____

    _____
13. If you are not in operation, have you tested you target market for product acceptance and profitability? Yes _____ No _____
14. Does your business have adequate financing: Yes _____ No _____
    Briefly explain: _____

    _____

    _____
15. What is you production goal (i.e., number of units per production run?)

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(A minimum of 10 hrs. per month is required for new kitchen users. After 6 months, a minimum of 20 hrs. is required.)

16. What hours of the day do you wish to use Kitchen Incubator facilities?
    (for example, 7:00 a.m. to 3:00 p.m.) _____ to _____
17. What alternate times would you prefer if you cannot be scheduled for your desired time? _____ to _____
18. What day(s) do you wish to use the Kitchen Incubator facilities? Please check all that apply:

    ☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday

    ☐ Saturday ☐ Sunday

    ☐ Day ☐ Night ☐ After Hours
19. Do you currently need storage space? ☐ Yes ☐ No
    If so, which type of storage and how many units?