Health, Housing & Human Services
CLACKAMAS COUNTY

TOURIST FACILITY LICENSE APPLICATION

Environmental Health Department

Phone: 503.655.8384 - Fax: 503.742.5352

Facility # ______________________

Facility:

Name: ____ Telephone number: _________________________

Mailing address: ____

Location if other than above: ____

Applicant/Owner:

Name: ____ Telephone number: _________________________

Mailing address: ____

Email address: ____

Manager (if other than applicant):

Name: ____ Telephone number: _________________________

Date applicant commenced business at this facility: ________________________

Has name of facility been changed within past year? ☐ Yes ☐ No - Former name: ___________________________

PLEASE CHECK AND COMPLETE THE FOLLOWING AS APPLICABLE:

1. The operation is: ☐ Year around ☐ Seasonal
2. Application is for a: _____ Recreation Park _____ Picnic Park _____ Organizational Camp
   _____ Travelers Accommodation _____ Bed & Breakfast
3. Please indicate as follows: ________ Number of cabins, units if travelers accommodations
   ________ Number of campsites and overnight spaces if recreation park
   ________ Number of beds or capacity if hotel or organizational camp

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APPLICANT CERTIFICATION

By signing below I, (facility operator) ________________________________, do here by certify and declare that I have read Oregon Revised Statutes (ORS) 446.310 through ORS 446.350, as well as the applicable Oregon Administrative Rules (OARs), and that I understand the requirements contained therein. I further certify and declare, based on my own personal knowledge, that the tourist facility for which this application is being made is currently in compliance with all applicable ORS and OAR requirements, and that there have been no substantial changes in conditions or procedures at the facility since the most recent inspection. I understand that making a false certification within this application may result in prosecution for a misdemeanor pursuant to ORS 162.085, and will result in the automatic denial of the license applied for.

______________________________ ______________________________

Signature of Operator **Date**

A LICENSE FEE OF $ _______ MUST ACCOMPANY THIS APPLICATION.

MAKE ALL CHECKS PAYABLE AND MAIL TO: CLACKAMAS COUNTY COMMUNITY HEALTH DIVISION 2051 KAEN ROAD #367, OREGON CITY, OREGON 97045

ALL LICENSES ISSUED ARE NON-TRANSFERABLE AND EXPIRE DECEMBER 31 OF THE YEAR OF ISSUE.

DO NOT WRITE IN THIS SPACE

APPROVED BY: ____ DATE APPROVED: __________________

REMARKS ____