Washington County Health Department

1302 Pennsylvania Avenue, Hagerstown, MD 21742

washcohealth.org
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CAMPGROUND PERMIT APPLICATION

CAMPGROUND INFORMATION

Campground Name _____

Campground Address _____

_____

Exact Location of Campground _____

_____

Campground Telephone _____ Campground Email Address _____

OWNER INFORMATION

Owner Name _____

Owner Address _____

_____

Owner Telephone _____ Owner Email Address _____

Name/Title of Applicant _____

Permit Mailing Address _____

_____

Date Campground Opens _____ Closes _____

Approximate Number of Sites or Accommodations _____

Type of Water Supply _____

Type of Sewage Disposal _____

Type of Garbage Disposal _____

Is Food to be Sold? _____ YES _____ NO

_____ _____

Signature **Date**

Returned check fee $25

OFFICE USE ONLY

RECEIPT NO. _____ PERMIT NO. _____ DATE ISSUED _____

Rev Oct 2022

ENVIRONMENTAL HEALTH

240-313-3400 Voice • 800-552-7724 TDD • 240-313-3424 Fax
wchd.eh@maryland.gov

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STATEMENT OF WORKERS' COMPENSATION INSURANCE

Maryland Health-General Code Annotated Section l-202 requires that before any license or permit be issued under the Health-General Article to an employer to engage in an activity in which the employer may employ any individual, the employer must file with the issuing authority a certificate of compliance with the State workers' compensation laws indicating the employer's workers' compensation insurance policy or binder number.

Circle the number of the option below which applies to you, provide the requested information, sign and date the form, and return it with the attached application.

1. I have workers' compensation insurance.

   Insurance Company _____

   Policy or Binder number _____

2. A waiver has been received from the Workers' Compensation Commission. (ATTACH A COPY OF THE WAIVER.)

3. As provided by Maryland Annotated Code Article 101, I am exempt from having workers' compensation insurance. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE.)

4. I am self-insured. Approval of self-insurance has been received from the Workers' Compensation Commission. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE.)

_____	_____
Date	Signature
_____	_____
Company Name	Title
_____	_____
Address	Type of License
_____ ___ _____	
City St Zip	