CLIFTON HEALTH DEPARTMENT
900 Clifton Ave.
Clifton, NJ 07013

APPLICATION FOR ROOMING HOUSE PERMIT

The undersigned hereby makes application for a Permit to operate a Rooming House in accordance with previsions of the ordinance 273-19 of the City of Clifton.
Rooming House Fee: $50.00

Applicant's signature _____

Applicant's signature _____

Clifton, NJ - Date: _____ 20 __

1. Location (Street and Number) _____
2. Block _____ Lot _____
3. Present Use _____
4. Proposed Use _____
5. Total Number of Rooms in Building _____
6. Number of Rooms to be Rented _____
7. Number of Rooming Units Rented _____
8. Will Central Kitchen be used by Roomers? _____
9. Is Cellar, Basement, or Attic, used for Living Purposes? _____
10. Has Certificate of Occupancy been obtained? _____
11. If "YES" Write the number of same _____
12. In Spaces Below, List the Number of Occupants in each Unit _____
13. Owner Phone Number: _____
14. Owner E-Mail: _____

Number of Tenants

	1st Floor	2nd Floor	3rd Floor	Attic	Basement
Rooming Unit No. 1					
Rooming Unit No. 2					
Rooming Unit No. 3					
Rooming Unit No. 4					
Rooming Unit No. 5					

(OVER)

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15. In the spaces below, list the number and location of complete bathrooms provided (toilets-baths-basins-urinals-and type of flooring).

	# of Toilets	# of Baths	# of Basins	# of Urinals	Types of Flooring
First Floor					
Second Floor					
Third Floor					
Attic					
Basement					

Comments:_____
_____
_____

_____ states that they have read the above application, and that all statements made therein are true.

_____ _____
Signature of Witness Signature of Applicant

_____ _____
Print Name Print Name

_____ _____
Date Date

REPORT OF EXAMINATION
CITY OF CLIFTON
(Office use only)

To the Public Health Authority:

Dear Sir: -- I respectfully report that I have examined the within described building and find the same in a satisfactory condition for issuance of a Rooming House Permit.

BUILDING DEPARTMENT (New Application ONLY)

Date of Approval: _____ _____ Inspector
_____ Title

FIRE DEPARTMENT (ANNUAL)

Date of Approval: _____ _____ Inspector
_____ Title

HEALTH DEPARTMENT (ANNUAL)

Date of Approval: _____ _____ Inspector
_____ Title