

**BUCKS COUNTY DEPARTMENT OF HEALTH  
APPLICATION MOBILE HOME COMMUNITY REGISTRATION**

Municipality: \_\_\_\_\_ ID#: \_\_\_\_\_  
Township/Borough

Mobile Home Community Name: \_\_\_\_\_

Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Street City/Town Zip Phone #

Owner's Name: \_\_\_\_\_

Address: \_\_\_\_\_ ( ) \_\_\_\_\_  
Street City/Town Zip Phone #

Mobile Home Community: Existent  Proposed

Total Number Mobile Home Spaces Provided: \_\_\_\_\_

Water Supply: Private  No.# of Wells \_\_\_\_\_

Public  \_\_\_\_\_  
Municipal Authority Name

Public Bathing Place Yes  No

Sewage Disposal: Public Sewers  \_\_\_\_\_ On-lot Sewage System   
Municipal Authority Name

Refuse/Trash Disposal Pick-up: \_\_\_\_\_  
Name of Trash Hauler

Food Service Provided Yes  No

Number of Service Buildings Provided: \_\_\_\_\_

Do you plan to expand Mobile Home Community area this year? Yes  No

If yes refer to Section 5.1 (Plan Reviews) in the Mobile Home Community Rules and Regulations

The undersigned attests that the above information is correct, and understands that the Certificate of Registration is subject to suspension or revocation under Section 3.3 & 3.4 of the Mobile Home Community Rules and Regulations for failure to comply with the requirements and subject to the penalty provisions set forth.

Make Check Payable to the: BUCKS COUNTY DEPARTMENT OF HEALTH

Mail Application to: Bucks County Department of Health  
Neshaminy Manor Center  
Doylestown, PA. 18901. Signature (owner): \_\_\_\_\_  
Date: \_\_\_\_\_

**Fee Schedule is based upon the number of mobile home spaces provided. See attached fee schedule.**

The fee required is dependent upon the accuracy of the information provided on this application. The spaces will be counted at inspection time and if not accurate a fee adjustment will be required prior to the issuance of the Certificate of Registration.

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**DO NOT WRITE BELOW DOTTED LINE FOR DEPARTMENT USE ONLY**

Appropriate Fee Received  Cash  Check  Money Order

Check No. \_\_\_\_\_ Dated: \_\_\_\_\_ Received By: \_\_\_\_\_