



TOWNSHIP OF FAIRFIELD
 BUREAU OF FIRE PREVENTION
 230 Fairfield Road
 Fairfield, New Jersey 07004
 Phone# 973-882-2700 ext. 2506
 Fax# 973-244-0178
 email: wsmith@fairfieldnj.org

Business Registration Form

Pursuant to the N.J. Uniform Fire Code, in effect in the Fairfield, you are hereby requested to supply the information listed below within THIRTY DAYS of receipt of this application.

FAILURE TO RESPOND TO THIS REGISTRATION SURVEY WITHIN THIRTY (30) DAYS WILL RESULT IN A PENALTY OF \$500.00 FOR EACH OCCURRENCE.

Business Details

Business Name: _____ Business Phone#: () - _____
 Business Address: _____ Business Address2: _____
E.g., 502 Pleasant Valley Ave Suite, Unit, Floor, eg., Suite 1
 Type of Ownership: Corporation LLC Partnership Condominium Private Gov.Agency Cooperative
 Type of Business: _____
 UFC Use Group: _____ Occupancy Load: _____
 Life Hazard Use: _____ LHU State ID#: _____
 Federal I.D.: _____ Hours of Operation: _____

Business Owner

Owner Name: _____ Owned by Corporation Individual
Corporate Name or if individual then First Last and Middle Name
 Owner Address: _____ Owner Address2: _____
Corporate or Residence address, eg., 100 Main st Suite, Apt, Floor, eg., Apt 1
 Owner City: _____ State: _____ Zip: _____
 Owner Phone: () - _____ Owner Mobile Phone#: () - _____
 Email Address: _____ Include in Emergency Contact List. If Yes, Contact Seq#

Building Owner Check if Building Owner is same as Business Owner(If different, complete the section below)

Owner Name: _____ Owned by Corporation Individual
Corporate Name or if individual then First Last and Middle Name
 Owner Address: _____ Owner Address2: _____
Corporate or Residence address, eg., 100 Main st Suite, Apt, Floor, eg., Apt 1
 Owner City: _____ State: _____ Zip: _____
 Owner Phone: () - _____ Owner Mobile Phone#: () - _____
 Email Address: _____ Include in Emergency Contact List. If Yes, Contact Seq#

Agent/Manager Check if Agent is same as Business Owner(If different, complete the section below)

Agent Name: _____ Agent Title: _____
First Last and Middle Name
 Agent Address: _____ Agent Address2: _____
Residence address, eg., 100 Main st Suite, Apt, Floor, eg., Apt 1
 Agent City: _____ State: _____ Zip: _____
 Agent Phone: () - _____ Agent Mobile Phone#: () - _____
 Email Address: _____ Include in Emergency Contact List. If Yes, Contact Seq#

Emergency Contacts (In addition to what is listed as Emergency Contacts Above)

Contact Order	Name (First Last and Middle Name)	Phone#	Alt Phone#	Email
_____	_____	() - _____	() - _____	_____
_____	_____	() - _____	() - _____	_____
_____	_____	() - _____	() - _____	_____

Construction	Year:	#of Floors:	Block:	Lot:		
<input type="checkbox"/> Attic	<input type="checkbox"/> Basement	<input type="checkbox"/> Roof Hatches	<input type="checkbox"/> SkyLights	<input type="checkbox"/> Exit Signs	<input type="checkbox"/> Emergency Lights	
<input type="checkbox"/> Fire Escape	Type					
<input type="checkbox"/> Elevators	Location					<input type="checkbox"/> Elevator Recall
Construction Type	<input type="checkbox"/> I-A High Rise	<input type="checkbox"/> I-B Mid Rise	<input type="checkbox"/> I-V Heavy Timber	<input type="checkbox"/> II-A Prot. Non-Comb	<input type="checkbox"/> II-B UnProt. Non-Comb	<input type="checkbox"/> III-A Prot.Comb
	<input type="checkbox"/> III-B UnProt.Comb	<input type="checkbox"/> V-A Port.Woodframe	<input type="checkbox"/> V-B UnPort. Woodframe			
Floor Construction	<input type="checkbox"/> Concrete	<input type="checkbox"/> Wood				
Bearing Walls	<input type="checkbox"/> Concrete	<input type="checkbox"/> Wood	<input type="checkbox"/> Block	<input type="checkbox"/> Brick	<input type="checkbox"/> Metal	<input type="checkbox"/> Other
Ceiling	<input type="checkbox"/> Plaster	<input type="checkbox"/> Wood	<input type="checkbox"/> Sheet Rock	<input type="checkbox"/> Acoustic	<input type="checkbox"/> Metal	<input type="checkbox"/> Other
Roof Covering	<input type="checkbox"/> Concrete	<input type="checkbox"/> Wood	<input type="checkbox"/> Reinf.Concrete	<input type="checkbox"/> Trusses	<input type="checkbox"/> Metal	<input type="checkbox"/> Other
Heating	<input type="checkbox"/> Oil	<input type="checkbox"/> Gas	<input type="checkbox"/> Electric	<input type="checkbox"/> Hot Water	<input type="checkbox"/> Hot Air	<input type="checkbox"/> Steam
Electric	<input type="checkbox"/> Fuses	<input type="checkbox"/> Circuit Breakers				
Electric Wiring	<input type="checkbox"/> EMT-Flexible	<input type="checkbox"/> Metal				
Trusses	<input type="checkbox"/> None	<input type="checkbox"/> Floor	<input type="checkbox"/> Roof	<input type="checkbox"/> Roof & Floor		
Truss Floor	<input type="checkbox"/> Wood	<input type="checkbox"/> Metallic	<input type="checkbox"/> Hybrid	<input type="checkbox"/> Pratt	<input type="checkbox"/> Parallel	
Truss Roof	<input type="checkbox"/> Common	<input type="checkbox"/> Scissors	<input type="checkbox"/> Bowstring	<input type="checkbox"/> Flat	<input type="checkbox"/> Cantilever	
# of Stairwells	<input type="checkbox"/> # Enclosed					
Exit Doors/#exists	<input type="checkbox"/> Fire Walls					
Entry Points						
Valid C.O.?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> N/A	Date Issued		

Area (in Sq. Feet)

Total Sq.Ft:	Building:	Basement:	LHU:
--------------	-----------	-----------	------

Extinguishers Yes No

Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Cooking Protected:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Alarms Yes No

SD Hard Wired:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Supervision Type:	<input type="checkbox"/> Not Monitored <input type="checkbox"/> Monitored Onsite <input type="checkbox"/> Monitored Remote <input type="checkbox"/> Auto Dialer		
Alarm Company:		Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Test Date: _____
SD Battery:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Supervision Type:	<input type="checkbox"/> Not Monitored <input type="checkbox"/> Monitored Onsite <input type="checkbox"/> Monitored Remote <input type="checkbox"/> Auto Dialer		
Alarm Company:		Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Test Date: _____
Heat Detectors:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Supervision Type:	<input type="checkbox"/> Not Monitored <input type="checkbox"/> Monitored Onsite <input type="checkbox"/> Monitored Remote <input type="checkbox"/> Auto Dialer		
Alarm Company:		Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Test Date: _____
Manual Pull:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Location:	
Supervision Type:	<input type="checkbox"/> Not Monitored <input type="checkbox"/> Monitored Onsite <input type="checkbox"/> Monitored Remote <input type="checkbox"/> Auto Dialer		
Alarm Company:		Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Test Date: _____

Sprinklers Yes No N/A Full Partial Basement Spray Booth

Sprinkler type:	<input type="checkbox"/> Wet <input type="checkbox"/> Dry <input type="checkbox"/> Wet/Dry <input type="checkbox"/> Anti Freeze <input type="checkbox"/> Deluge		
FDC Connection:	<input type="checkbox"/> Yes	Location:	
Supervision Type:	<input type="checkbox"/> Not Monitored <input type="checkbox"/> Monitored Onsite <input type="checkbox"/> Monitored Remote <input type="checkbox"/> Auto Dialer		
Alarm Company:		BackFlow Preventor:	<input type="checkbox"/> Yes
Maint. Company:		Test Records:	<input type="checkbox"/> Yes <input type="checkbox"/> No
			Test Date: _____

Fire Pumps Yes No Rated Capacity: _____

Location: _____ Head Pressure: _____

Power Source: Generator Line-Utility Solar Array Wind Turbine

Maint. Company: _____ Test Records: Yes No Test Date: _____

StandPipes Yes No Wet Dry

FDC Connection: Yes Location: _____

Supervision Type: Not Monitored Monitored Onsite Monitored Remote Auto Dialer

Hose Connection: _____ BackFlow Preventor: Yes

Alarm Company: _____ Test Records: Yes No Test Date: _____

Generators Yes No Power(KW): _____ Location: _____

Manufacture: _____ Fuel Type: _____

Supervision Type: Gas Diesel Natural Gas Propane

Test Records: Yes No Test Date: _____

Hood Systems Yes No Type1 Type2 Location: _____

Maint. Company: _____ Test Records: Yes No Test Date: _____

Other Systems Location: _____

Permits (Add additional sheets if needed)

Permit#	Permit Type	Issue Date	Expiration Date	Annual?
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>

Hazmat (Add additional sheets if needed)

S#	Chemical Name	Capacity	Activate Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional Information

Please Mail or Fax the completed form to the above address. Thank You.