



SANITARY INSPECTION REPORT

IDENTIFICATION					
OWNER INFORMATION <i>(Complete this section only if different from establishment information)</i>			ESTABLISHMENT INFORMATION		
NAME OF OWNER(S), CORPORATION OR REGISTERED AGENT			ESTABLISHMENT TRADING NAME <i>Marshall's</i>		
NUMBER AND STREET			NUMBER AND STREET <i>US 122 W Blue Star Shopping Ctr.</i>		
COUNTY			MUNICIPALITY <i>Watchung</i>		ZIP CODE
MUNICIPALITY		STATE	COUNTY <i>Summit</i>		TELEPHONE NO.
ZIP CODE	CO/MUN. CODE		ESTABLISHMENT STATE LICENSE NO. <i>(If Appl.)</i>		CO/MUN CODE
INSPECTION					
TYPE OF ESTABLISHMENT		ESTABLISHMENT CODE		1 <input type="checkbox"/> INITIAL INSPECTION	
1 <input checked="" type="checkbox"/> RETAIL				2 <input type="checkbox"/> REINSPECTION <i>(other than initial inspection)</i>	
2 <input type="checkbox"/> OTHER <i>(Specify):</i> <i>Convenience</i>		GOODS		TIME - (2400 HOURS)	
3 <input type="checkbox"/>		1 <input type="checkbox"/> DESTROYED		DATE	BEGIN
4 <input type="checkbox"/>		2 <input type="checkbox"/> EMBARGOED		<i>3/27/22</i>	END
EVALUATION					
<input checked="" type="checkbox"/> SATISFACTORY <input type="checkbox"/> CONDITIONALLY SATISFACTORY <input type="checkbox"/> UNSATISFACTORY					
OFFICIAL(S)					
LOCAL BOARD OF HEALTH			INSPECTING OFFICIAL		
NAME, ADDRESS AND <i>(print)</i>			NAME OF INSPECTOR		
<i>Middle Branch Regional Health Commission 111 Green Brook Rd Green Brook NJ</i>			<i>Robyn Key</i>		
TELEPHONE NUMBER			TITLE		
<i>(732) 968-5151 x2</i>			<i>SP. REHS.</i>		
NAME OF HEALTH OFFICER			INSPECTOR'S SIGNATURE		DATE
<i>K.G. Smoot</i>			<i>Robyn Key</i>		
			INSPECTOR'S PERM. REG. NO.		
			<i>B-1649</i>		

CONTINUATION SHEET
(for Inspections, Surveys, Audits, etc.)

NAME (Individual, Facility, Establishment, etc.)

DATE

MUNICIPALITY

TEL., CODE or ID NO.

ITEM
NO.

REMARKS

No food prep in this establishment. Only pre-packaged food product is sold here.

Food appears to be up to date.
Protected from contamination.
Bathrooms satisfactory

Satisfactory

SIGNATURE OF INDIVIDUAL COMPLETING FORM

SIGNATURE OF OWNER OF FACILITY, ESTABLISHMENT, ETC., IF
REQUIRED

PAGE OF PAGES

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