



Sabury  
Whinnery

7/07/23

### SANITARY INSPECTION REPORT

IDENTIFICATION					
<b>OWNER INFORMATION</b> <i>(Complete this section only if different from establishment information)</i>			<b>ESTABLISHMENT INFORMATION</b>		
NAME OF OWNER(S), CORPORATION OR REGISTERED AGENT			ESTABLISHMENT TRADING NAME		
NUMBER AND STREET			NUMBER AND STREET		
COUNTY			MUNICIPALITY		ZIP CODE
MUNICIPALITY		STATE	COUNTY		TELEPHONE NO.
ZIP CODE	CO/MUN. CODE		ESTABLISHMENT STATE LICENSE NO. (If Appl.)		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 (other than initial inspection)	
2 <input type="checkbox"/> OTHER (Specify):		GOODS		TIME - (2400 HOURS)	
3 <input type="checkbox"/>		1 <input type="checkbox"/> DESTROYED		DATE	BEGIN
4 <input type="checkbox"/>		2 <input type="checkbox"/> EMBARGOED		6/7/22	10:30 AM
					10:50 AM
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 (print)			NAME OF INSPECTOR		
Middle-Brook Regional Health Comm 111 Greedonor Rd Greene Brook CT			Robyn Kay		
TELEPHONE NUMBER			TITLE		
(732) 968-5151			Sr. REHS		
NAME OF HEALTH OFFICER			INSPECTOR'S SIGNATURE		DATE
K.G. Samner			[Signature]		
			INSPECTOR'S PERM. REG. NO.		
			B-1649		

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

NAME (Individual, Facility, Establishment, etc.) <i>Subway</i>	DATE <i>6/07/22</i>
MUNICIPALITY <i>Waichung</i>	TEL., CODE or ID NO.

ITEM NO.	REMARKS
(OS) 607	Hand washing across from the 3 Compartment Sink = no hand towels.
OK.	Steam table - meat Balls. 132°F. (135°F ideal)
OK.	Cold meats 41°F.
Great	Bulk Refrigerator 39°F.
Great	Bulk Freezer - 0°F.
-	Hand sink in the front - Satisfactory
Good	Hand washing was seen behind counter.
<del>Satisfactory</del>	

SIGNATURE OF INDIVIDUAL COMPLETING FORM <i>[Signature]</i>	SIGNATURE OF OWNER OF FACILITY, ESTABLISHMENT, ETC., IF REQUIRED <i>[Signature]</i>
PAGE	OF PAGES