



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 Stephanie + Rafael Oliveira		ESTABLISHMENT TRADING NAME Pour +ug & Coffee House, LLC	
NUMBER AND STREET 644 Rockview Ave.		NUMBER AND STREET 60 Stirling Rd.	
COUNTY Somerset, CT	MUNICIPALITY Leitchy NJ		ZIP CODE
MUNICIPALITY No. Plainfield	STATE NJ	COUNTY Somerset	TELEPHONE NO. 908-7603007
ZIP CODE	CO/MUN. CODE	ESTABLISHMENT STATE LICENSE NO. (If Appl.)	CO/MUN CODE
862-772-565			
INSPECTION			
TYPE OF ESTABLISHMENT 1 <input checked="" type="checkbox"/> RETAIL 2 <input type="checkbox"/> OTHER (Specify): 3 <input type="checkbox"/> 4 <input type="checkbox"/>	ESTABLISHMENT CODE	1 <input type="checkbox"/> INITIAL INSPECTION 2 <input type="checkbox"/> REINSPECTION (other than Initial Inspection)	
	GOODS 1 <input type="checkbox"/> DESTROYED 2 <input type="checkbox"/> EMBARGOED	TIME - (2400 HOURS)	
		DATE 1/17/23	BEGIN 1000 H
			END 10:30 HS
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 Robyn K	
		TITLE Sr. REHS	
TELEPHONE NUMBER (732) 968-5151		INSPECTOR'S SIGNATURE [Signature]	
NAME OF HEALTH OFFICER K.G. Summer		INSPECTOR'S PERM. REG. NO.	DATE

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

NAME (Individual, Facility, Establishment, etc.) <i>Portuguese Watchman</i>	DATE <i>1/18/23</i>
MUNICIPALITY <i>WATCHMAN</i>	TEL., CODE or ID NO.

ITEM NO.	REMARKS
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Note: There meter is needed in display case.
(There is a digital there meter).

6.2. The meter is needed in refrigerator under
expresso machine.

Note: Both the employee Bathroom + Customer Bathroom
are satisfactory.

7.1 Chemical storage must be relocated
from above ice machine.

SIGNATURE OF INDIVIDUAL COMPLETING FORM

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