**BOARD OF HEALTH**
Merridith A. O'Leary, R.S.
Director of Public Health

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## FOR BOARD OF HEALTH USE ONLY

Date Received: _____ Amount Received: _____ Cash/Check No: _____ Received by: _____

# 2018 Food Establishment Permit Application

*(Application must be submitted at least 30 days before the planned opening date)*

ALL FEES PAID ARE NON-REFUNDABLE

**NO PERMITS WILL BE ISSUED IF TAXES ARE OWED**

| | |
|---|---|
| Corporation Name: | Corporation Address: |
| Establishment Name: (dba): | Establishment Tel. # |
| Establishment Address: | Email: |
| Establishment Mailing Address (if different): | |
| | |
| Applicant Name (Permit Holder): | |
| Applicant Title: | |
| Applicant Address: | |
| Applicant Telephone #: | 24 Hour Emergency #: |
| Owner Name & Title (if different from applicant): | |
| Owner Address (if different from applicant): | |

| Establishment Owned By: | If a corporation or partnership, give name, title, and home address of officers or partner |
|---|---|
| 0 An association<br>0 A corporation<br>0 An individual<br>0 A partnership<br>0 Other legal entity | Name Title Home Address |

**Person Directly Responsible For Daily Operations (Owner, Person In Charge, Supervisor, Manager etc.)**

Name & Title:

Address:

Telephone #: Cell/Pager# Email:

Emergency Contact:

Food Establishment Information

| | | | | |
|---|---|---|---|---|
| Days and Hours of Operation: | | | | |
| Name of Person in Charge Certified in Food Protection Management:<br>(Required as of 10/1/2001 in accordance with 105 CMR 590.003(A) Please attach copy of certificate.) | | | | |
| Person Trained In Anti-Choking Procedures (if 25 seats or more) : **O** Yes **O** No<br>(In accordance with 105 CMR 590.009) | | | | |
| Name of Person Trained in Food Allergen Awareness :<br>(In accordance with 105 CMR 590.003(B) Please attach copy of certificate) | | | | |
| Water Source:<br>**O** Public<br>**O** Well<br><br>Sewage Disposal:<br>**O** Public<br>**O** Septic | **Establishment Type** (check all that apply & enter applicable permit cost) | | | |
| | **O Retail Food** ($100 base + Sq. ft. based on attached chart)<br>$100 base +_____ | $_____ | **O Frozen Dessert Manufacturer**<br>Name of Testing Lab:<br>_____ | $5.00 |
| | **O Food Service Establishment** - ($100 base + Number of Seats based on Occupancy Permit: Fee Chart attached)<br>$100 base + _____ | $_____ | **O Bar** - No food preparation, pre-packaged food only. | $100.00 |
| | **O Bed and Breakfast** | $100.00 | O **Caterer** | $100.00 |
| | | | **TOTAL** | $ |

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the Board of Health on how to obtain copies of 105 CMR 590.000 and the Federal Food Code.

Signature of Permit Holder: _____

Pursuant to MGL Chapter 62C, Section 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid state taxes required under law.

Signature of Corporate Representative (i.e. President, CFO, COO):_____