

FOR BOARD OF HEALTH	DATE RECEIVED:	DATE ISSUED:	PERMIT NO. FSE (RES)	YEAR <b>2012</b>
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# APPLICATION FOR PERMIT TO OPERATE A FOOD SERVICE ESTABLISHMENT

CASH

CHECK



NORTHAMPTON BOARD OF HEALTH  
212 MAIN STREET  
NORTHAMPTON, MA 01060  
(413) 587-1214

**LICENSE FEE: \$100.00**

Date: \_\_\_\_\_

Name of Establishment: \_\_\_\_\_

Business Address: \_\_\_\_\_

Mailing Address (If different): \_\_\_\_\_

Name & Title of Applicant: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_

Name of Owner (If different): \_\_\_\_\_

If corporation or partnership, give name, title & home address of officers or partners.

<u>Name</u>	<u>Title</u>	<u>Home Address</u>

State of Incorporation \_\_\_\_\_ Name & Address of Local Agent \_\_\_\_\_

Type of Establishment	Fee	Duration of Permit	Amount to be Paid Total Fee(s):
Retail Food <input type="checkbox"/>	_____	Annual <input checked="" type="checkbox"/>	<b>\$100.00</b>
Food Service <input type="checkbox"/>	_____	Seasonal <input type="checkbox"/>	
Bar Service <input type="checkbox"/>	_____	Temporary <input type="checkbox"/>	Fill in all information on <b>page 2</b> listing all food items To be prepared and distributed – Only foods that are non-potentially hazardous are allowed. Residential Wholesale operations are not allowed.
Caterer <input type="checkbox"/>	_____		
Mobile Food <input type="checkbox"/>	_____		
Mobile Retail <input type="checkbox"/>	_____		
<u>Residential</u> <input checked="" type="checkbox"/>	<b>\$100.00</b>		
Bed & Breakfast <input type="checkbox"/>	_____		

ADDITIONAL INFORMATION: Water Source \_\_\_\_\_ Sewage Disposal \_\_\_\_\_

\_\_\_\_\_  
Social Security or Federal ID#

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
Telephone #

\_\_\_\_\_  
Signature of Individual or Corporate Officer

**PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON**

Turn Over

THIS PRODUCT LIST MUST BE FILLED OUT PRIOR TO EVALUATION AND LICENSE ISSUANCE.

## RESIDENTIAL KITCHEN PRODUCT LIST

TYPE OF FOOD PRODUCT MANUFACTURED	LIST OF INGREDIENTS (In order of predominance by weight)	LOCATION AND NAME OF ESTABLISHMENT(S) WHERE SOLD
PRODUCT 1		
PRODUCT 2		
PRODUCT 3		
PRODUCT 4		
PRODUCT 5		
PRODUCT 6		
PRODUCT 7		
PRODUCT 8		
PRODUCT 9		
PRODUCT 10		

IT IS NOT NECESSARY TO FILL THIS CHART OUT IF YOU HAVE ALREADY DONE SO AND THERE ARE NO CHANGES IN THE INFORMATION THAT THE BOARD OF HEALTH ALREADY HAS ON FILE.

***SIMPLY CHECK THE BOX TO THE RIGHT.***

**NO CHANGES**