

APPLICATION FOR PERMIT

FOOD SERVICE ESTABLISHMENTS 2012

**APPLICATION MUST BE FILLED OUT COMPLETELY**

Name/Map/Lot \_\_\_\_\_

Mailing Address \_\_\_\_\_

Town/State/Zip \_\_\_\_\_

Business Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Owner's Name \_\_\_\_\_ Home Tel. \_\_\_\_\_ E-Mail \_\_\_\_\_

Manager's Name \_\_\_\_\_ Home Address \_\_\_\_\_

(No. Street) (Town) (State) (Zip)

If Corporation or Partnership, give name, title and home address of officers or partners.

Name Title Home Address

Establishment is open \_\_\_\_\_ months a year. Total seating capacity \_\_\_\_\_ Take-out service only? \_\_\_\_\_

Name of Certified Food Handler (s) \_\_\_\_\_ P.I.C. \_\_\_\_\_

Does establishment have outside seating? \_\_\_\_\_ Seating Capacity \_\_\_\_\_ Is area enclosed? \_\_\_\_\_ Capacity \_\_\_\_\_

If seating capacity are over 25, person Chokesaver Certified \_\_\_\_\_

Applications for all licenses/permits required by the Board of Selectmen have been filed for the year 2012 yes \_\_\_\_\_ no \_\_\_\_\_

**PLEASE CHECK PERMIT (S) YOU ARE APPLYING FOR:**

- |   |  |
|---|--|
| <input type="checkbox"/> Temporary Food Service | <input type="checkbox"/> Caterer             |
| <input type="checkbox"/> Retail Food            | <input type="checkbox"/> Food Service        |
| <input type="checkbox"/> Mobile Unit            | <input type="checkbox"/> Residential Kitchen |
| <input type="checkbox"/> Bed & Breakfast        |  |

**FOR FOOD SERVICE ESTABLISHMENTS:** Are you compliant with the new Food Allergen Requirements: yes \_\_\_\_\_ no \_\_\_\_\_

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

\_\_\_\_\_  
\* Signature of Individual or Corporate Name (mandatory)

\_\_\_\_\_  
By: Corporate Officer (mandatory, if applicable)

\_\_\_\_\_  
\*\*Social Security/ Federal Identification Number. **(MANDATORY)**

\* This license will not be issued unless this certification clause is signed by the applicant.

\*\* Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation.

This request is made under the authority of M.G.L. Chapter 62C Section 49A.

\_\_\_\_\_  
Health Agent

\_\_\_\_\_  
Date

Date Received \_\_\_\_\_ By (initials) \_\_\_\_\_ Fee \_\_\_\_\_ Date Issued \_\_\_\_\_

***PERMITS ARE NOT TRANSFERABLE FROM A PERSON OR A PLACE***