



The Commonwealth of Massachusetts
TOWN OF HOLDEN
BOARD OF HEALTH
 1196 Main Street, Holden, MA 01520
 Phone 508-829-0254 Fax 508-829-0252

APPLICATION FOR PERMIT TO OPERATE A FOOD ESTABLISHMENT

Date: _____
 Name of Establishment: _____
 Business Address: _____
 Telephone: _____ Fax: _____
 Mailing Address (if different): _____
 Print Name & Title of Applicant: _____
 Address of Applicant: _____
 Name of Owner: _____ Telephone: _____

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

<u>NAME</u>	<u>TITLE</u>	<u>HOME ADDRESS</u>

State of Incorporation: _____ Name and Address of Local Agent: _____
 Emergency Response Person: _____ Telephone: _____

<u>TYPE OF ESTABLISHMENT</u>	<u>FEE</u>	<u>FEE DUE</u>
Caterer	\$ 40	_____
Catered Event	\$ 30	_____
Church - limited food service	\$N/C	_____
* Mobil Food Unit	\$ 50	_____
Vendor	\$ 30	_____
Residential Kitchen	\$ 30	_____
Temporary	\$ 30	_____
Restaurant		
Under fifty seats	\$150	_____
Fifty seats and over	\$200	_____
Retail Food Store		
Under 8,000 s.f.	\$100	_____
8,000 s.f. and over	\$200	_____
TOTAL PAYMENT		\$ _____ (due with application)

Dates of operation (if not annual): _____

*Applications for mobile food units or pushcarts must include a list of the handwash and toilet facilities available on each route. Please attach a separate sheet.

P L E A S E S E E R E V E R S E S I D E

Food Service Application - Page 2

Water Source: _____ Sewage Disposal: _____

Days and hours of operation: _____

If Restaurant:

Number of seats: _____ Number on non-smoking seats: _____

Person trained in <u>anti-choking</u> procedures (if 25 seats or more): _____ <p style="text-align: center;"><i>Yes</i> <i>No</i></p> Name: _____

* Person trained in food service: (Trained & Certified ServSafe Certified) _____ <p style="text-align: center;"><i>Yes</i> <i>No</i></p> Name: _____ Certification Expires: _____
--

ATTENTION: Certificate of insurance with workman's compensation for establishment, and copy of food managers/handlers certification required with application.

Signature of Applicant

Pursuant to M.G.L. Ch. 62C, Sec. 49A, I certify under penalties of perjury that I, to my best knowledge and belief have filed all state tax returns and paid all taxes required under law.

SS Number or Federal I.D. #

Signature of Individual or Corp. Name

By: _____
Corporate Officer (if applicable)

*** THE HOLDEN BOARD OF HEALTH MUST BE NOTIFIED IF THERE IS A CHANGE IN PERSONNEL.**

FOR BOARD OF HEALTH USE ONLY

_____ Date Received	_____ Date Inspected	_____ Approved By	_____ Permit # Issued
-------------------------------	--------------------------------	-----------------------------	---------------------------------

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP)
ATTESTATION

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 # (Voluntary) or Federal Identification Number

* 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 Mass. G.L. c. 62C s. 49A.