

Town of East Bridgewater Food Permit Application

(Permits expire every December 31st)

1) Establishment Name:													
2) Establishment Address:													
3) Establishment Mailing Address & Email:													
4) Establishment Phone:													
5) Applicant Name & Title													
6) Applicant Address:													
7) Applicant Phone:													
8) Owner Name & Title (if different from applicant)													
9) Owner Address (if different from applicant)													
<p>10) Establishment Owned By:</p> <p>An Association <input type="checkbox"/></p> <p>A Corporation <input type="checkbox"/></p> <p>An Individual <input type="checkbox"/></p> <p>A Partnership <input type="checkbox"/></p> <p>Other Legal Entity <input type="checkbox"/></p>	<p>11) If a corporation or partnership, give name, title and home address of officers or partner.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Title</th> <th style="text-align: left; border-bottom: 1px solid black;">Address</th> </tr> </thead> <tbody> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>	Name	Title	Address	_____	_____	_____	_____	_____	_____	_____	_____	_____
Name	Title	Address											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
12) Persons Directly Responsible for Daily Operation (Owner, Person in Charge, Supervisor, Manager Etc.)													
Name & Title:													
Address:													
Telephone #:													
Emergency #:													
Fax:	Email Address:												
13) Regional Supervisor or District (If Applicable)													
Name & Title													
Address & Phone #:													

Food Establishment Information

14) Water Source:	15) Sewage Disposal:
16) Days and Hours of Operation	17) No. of Food Employees
18) Name of Person In Charge Certified In Food Protection Management & Allergen Awareness	22) Establishment Type: Check all that apply
19) Person Trained in Anti-Choking Procedures: (if 25 Seats or more) Yes <input type="checkbox"/> No <input type="checkbox"/>	Retail Food..... \$175.00 <input type="checkbox"/> Food Service.....\$175.00 <input type="checkbox"/> Residential Kitchens.....\$50.00 <input type="checkbox"/> Mobile Food (annual).....\$100.00 <input type="checkbox"/> Mobile Food (seasonal - April - October).....\$50.00 <input type="checkbox"/> Milk & Cream.....\$10.00 <input type="checkbox"/> Food Service Est. Plan Review Fee.....\$100.00 <input type="checkbox"/> Frozen Food & Desert.....\$50.00 <input type="checkbox"/> Tobacco.....\$125.00 <input type="checkbox"/> Public, Church, Charity Food.....No Charge <input type="checkbox"/>
20) Location: Check One Permanent Structure <input type="checkbox"/> Mobile <input type="checkbox"/>	
21) Length Of Permit: Check One Annual Seasonal Dates: Temporary Dates/Times 22) Are taxes/fees more than 30 days in arrears: Yes or No	

Today's Date: _____

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.

24) Signature of Applicant: _____

Pursuant to MGL Ch. 62C, sec. 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.

25) Social Security Number or Federal ID: _____

26) Signature of Individual or Corporate Name: _____

Board of Health Use Only

Date Received:	Payment Received:	Check #	Permit #
Date Approved:	Date Inspected:	Approved By:	