FOR BOARD OF HEALTH USE ONLY			
Date Received	Date Inspected	Approved by	Permit # Issued
_____	_____	_____	_____

THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF CARVER

Food Establishment Permit Application

(*Application must be submitted at least 30 days before the planned opening or expiration date of current permit)*

1. Establishment Name:

2. Establishment Address:

3. Establishment Mailing Address:

4. Establishment Telephone No:

5. Applicant Name & Title:

6. Applicant Address:

7. Applicant Telephone No: Email Address:

8. Owner Name & Title (if different from applicant):

9. Owner Address (if different from applicant):

10. Establishment Owned By:

- ☐ An Association
- ☐ A Corporation
- ☐ An Individual
- ☐ A Partnership
- ☐ Other Legal Entity_____

11. If a Corporation or Partnership, give name, title and home address of officers or partner.

Name	Title	Home Address

12. Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager, etc.)
Name & Title:

Address:

Telephone No:

Emergency Telephone No: Fax:

13. District or Regional Supervisor (*if applicable*)
Name & Title:

Address:

Telephone No: Fax:

Adapted from Hobbs & Warren Form 734

Food Establishment Information

14. Water Source:

Sewage Disposal:

15. No. of Inside Seats:

No. of Outdoor Seats:

16. Days and Hours of Operation:

17. No. of Food Employees:

18. Name of Person in Charge Certified in Food Protection Management:
Required as of 10/1/2001 in accordance with 105 CMR 590.003(A). Please attach copy of certificate.

19. Person Trained in Anti-Choking Procedures (if 25 seats or more): Yes ☐ No ☐

20. Location

☐ Permanent Structure
☐ Mobile

21. Length of Permit

☐ Annual
☐ Seasonal
☐ Temporary - Dates of Operation for Seasonal or Temporary Permits:

22. Establishment Type (check all that apply)

☐ Retail (Sq. Ft.)
☐ Food Service –
☐ Food Service – Takeout
☐ Food Service – Institution (Meals/Day)
☐ Other (Describe)
☐ Caterer
☐ Food Delivery
☐ Residential Kitchen for Retail Sale
☐ Residential Kitchen for Bed & Breakfast Home
☐ Residential Kitchen for Bed & Breakfast Establishment
☐ Frozen Dessert Manufacturer

23. Food Operations:
(Check all that apply)

Definitions: PHF – potentially hazardous food (time/temperature controls required)
Non-PHF's – non –potentially hazardous food (no time/temperature controls required)
RTE – ready to eat foods (ex. Sandwiches, salads, muffins which need no further processing)

☐ Sale of Commercially Pre-Packaged Non-PHF's `	☐ PHF Cooked to Order	☐ Hot PHF Cooked and Cooled or Hot Held for more than a single meal service
☐ Sale of Commercially Pre-Packaged PHF's	☐ Preparation of PHF's for Hot and Cold Holding for Single Meal Service	☐ PHF and RTE Foods Prepared for Highly Susceptible Population Facility
☐ Delivery of Packaged PHF's	☐ Sale of Raw Animal Foods Intended to be Prepared by Consumer	☐ Vacuum Packaging/Cook Chill
☐ Customer Self-Service	☐ Reheating of Commercially Processed Foods for Service within 4 hours	☐ Use of Process Requiring a Variance and/or HACCP Plan (including bare hand contact Alternative, time as a public health control)
☐ Customer Self-Service of Non- PHF and Non-Perishable Foods Only	☐ Ice Manufactured and Packaged for Retail Sale	☐ Offers Raw or Undercooked Food of Animal Origin
☐ Preparation of Non-PHF's	☐ Juice Manufactured and Packaged For Retail Sale	☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service
☐ Offers RTE PHF in Bulk Quantities	☐ Retail Sale of Salvage, Out of Date or Reconditioned Food	*To be completed by the Board of Health* **Total Permit Fee:_____** **Payment is due with application**

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:_____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette, Boston, MA 02111-1750
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name:_____

Address:_____

City/State/Zip:_____ Phone #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name:_____

Insurer's Address:_____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date:_____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under § 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature:_____ Date:_____

Phone #:_____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #**_____

Issuing Authority (check one):

1. ☐ **Board of Health** **2.** ☐ **Building Department** **3.** ☐ **City/Town Clerk** **4.** ☐ **Licensing Board**
5. ☐ **Selectmen's Office** **6.** ☐ **Other** _____

Contact Person:_____ **Phone #:**_____