TOWN OF TEWKSBURY
BOARD OF HEALTH
@ THE SENIOR CENTER
175 CHANDLER STREET
TEWKSBURY, MASSACHUSETTS 01876

Lou-Ann C. Clement, C.H.O.
Director of Public Health

(978) 640-4470
Fax: (978) 640-4472

APPLLICATION FOR A PERMIT TO OPERATE A FOOD ESTABLISHMENT

Date:_____

Name of Establishment:_____ Telephone #:_____

Business Address:_____

Mailing Address (if different):_____

Name & Title of Applicant:_____

Address of Applicant:_____

Name of Owner (if different from applicant):_____ Telephone #:_____

Email Address:_____

If Corporation of partnership gives name, title and home address of officers or partners.

Name:_____ Title: _____ Home Address:_____

Name:_____ Title:_____ Home Address:_____

Name:_____ Title:_____ Home Address:_____

State of Incorporation:_____ Name & Address of Local Agent:_____

Does your establishment have an emergency response plan in place: YES _____ NO _____

Emergency Response Person:_____ Home Phone:_____

Address:_____ Cell Phone: _____

TYPE OF FOOD ESTABLISHMENT			DURATION OF PERMIT:			AMOUNT DUE:
Retail (Small)	☐	$160.00				
Convenience Store	☐	$170.00	Annual	☐	List Dates:	
Super Market	☐	$275.00				
Food Service	☐	$215.00				
Bakery	☐	$180.00				
Caterer	☐	$185.00	Seasonal	☐	List Dates:	
Mobile Food*	☐	$110.00				
Service Club	☐	$ 65.00				
Milk Truck	☐	$ 35.00				

PAYMENT DUE WITH APPLICATION:_____

*Applications for mobile food units or pushcarts must include a list of the hand wash and toilet facilities available on each route.

ADDITIONAL INFORMATION:

_____ Water Source

_____ Sewage Disposal

IF RESTAURANT:

Number of Seats: _____

Person Trained in Anti-Choking Procedures (IF 25 seats or more).
YES ☐ NO ☐
Include Current Certificates

CERTIFICATIONS:
(IF more than one person, please list on separate sheet)

☐ **Food Safety Certificate** _____ _____
Name of Certificate Holder **Date of Expiration**

☐ **Allergen Certificate** _____ _____
Name of Certificate Holder **Date of Expiration**

☐ **Anti-Choking Certificate*** _____ _____
Name of Certificate Holder **Date of Expiration**

***ANTI-CHOKING FOR 25 SEATS OR MORE**

REMINDERS:

- **All menus are to list "Consumer Advisory: consuming raw or undercooked foods" statement when applicable.**
- **All menus are to list the Allergens Awareness statement.**
- **Allergen postings are required in the kitchen area.**
- **All establishments are required to maintain a copy of the State Sanitary code "Minimum Standards for Food Establishments, Article X" within their facility.**

ATTACH THE FOLLOWING APPLICABLE DOCUMENTS:

- **"Workers' Compensation Insurance Affidavit: General Business" (signed by you)**
- **Insurance Binder with your facility name and address (from your insurance company)**

X _____
SIGNATURE OF APPLICANT

Pursuant to M.G.L. 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 all state taxes required under law.

_____ _____ _____
Social Security Number or Federal Signature of Individual or Corporate Name Corporate Officer

COMMENTS:

FOR BOARD OF HEALTH USE ONLY

_____ _____ _____ _____
Date Received Check Number Amount Paid Permit # Issued

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
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 Section 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 (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ Phone #: _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an ***employee*** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An ***employer*** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that **"every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required."** Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia

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