



TOWN OF TEWKSBURY

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

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Director of Public Health

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APPLICATION 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)	<input type="checkbox"/>	\$160.00		_____
Convenience Store	<input type="checkbox"/>	\$170.00	Annual <input type="checkbox"/>	List Dates: _____
Super Market	<input type="checkbox"/>	\$275.00		_____
Food Service	<input type="checkbox"/>	\$215.00		_____
Bakery	<input type="checkbox"/>	\$180.00		
Caterer	<input type="checkbox"/>	\$185.00	Seasonal <input type="checkbox"/>	List Dates: _____
Mobile Food*	<input type="checkbox"/>	\$110.00		
Service Club	<input type="checkbox"/>	\$ 65.00		
Milk Truck	<input type="checkbox"/>	\$ 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)

✕ _____
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