

Date Received	<b>FOR BOARD OF HEALTH USE ONLY</b>	Date Inspected	Approved By	Permit # Issued
---------------	-------------------------------------	----------------	-------------	-----------------

THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF WELLESLEY 90 WASHINGTON STREET WELLESLEY, MA 02481

## Food Establishment Permit Application

*(Application must be submitted at least 30 days before the planned opening date)*

1. Establishment Name:																
2. Establishment Address:																
3. Establishment Mailing Address (if different):																
4. Establishment Telephone No:																
5. Applicant Name & Title:																
6. Applicant Address:																
7. Applicant Telephone No:	24 Hour Emergency No:															
8. Owner Name & Title (if different from applicant):																
9. Owner Address (if different from applicant):																
10. Establishment Owned By: <input type="checkbox"/> An Association <input type="checkbox"/> A Corporation <input type="checkbox"/> An Individual <input type="checkbox"/> A Partnership <input type="checkbox"/> Other Legal Entity	11. If a Corporation or Partnership, give name, title, and home address of officers or partner. <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;"><u>Name</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Title</u></th> <th style="text-align: left; border-bottom: 1px solid black;"><u>Home Address</u></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> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	<u>Name</u>	<u>Title</u>	<u>Home Address</u>												
<u>Name</u>	<u>Title</u>	<u>Home Address</u>														
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:															

# Food Establishment Information

14. Water Source:  DEP Public Water Supply No.: <i>(if applicable)</i>		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: <i>Required as of 10/1/2001 in accordance with 105 CMR 590.003(A) Please attach copy of certificate.</i>			
19. Person Trained in Anti-Choking Procedures (if 25 seats or more): <input type="checkbox"/> Yes <input type="checkbox"/> No			
20. Location <i>(check one)</i> <input type="checkbox"/> Permanent Structure <input type="checkbox"/> Mobile		22. Establishment Type (check all that apply) <input type="checkbox"/> Retail (            Sq. Ft.) <input type="checkbox"/> Food Service – (            Seats) <input type="checkbox"/> Food Service – Takeout <input type="checkbox"/> Food Service – Institution (            Meals/Day) Other (Describe)	
21. Length Of Permit: <i>(check one)</i> <input type="checkbox"/> Annual <input type="checkbox"/> Seasonal/Dates:  <input type="checkbox"/> Temporary/Dates/Time:		<input type="checkbox"/> Caterer <input type="checkbox"/> Food Delivery <input type="checkbox"/> Residential Kitchen for Retail Sale <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Establishments <input type="checkbox"/> Frozen Dessert Manufacturer	
23. Food Operations: <i>(check all that apply):</i>		<i>Definitions: PHF – potentially hazardous food (time/temperature controls required)</i> <i>Non-PHF's – non-potentially hazardous food (no time/temperature controls required)</i> <i>RTE – ready-to-eat foods (Ex. sandwiches, salads, muffins which need no further processing)</i>	
<input type="checkbox"/> Sale of Commercially Pre-Packaged Non-PHF's	<input type="checkbox"/> PHF Cooked To Order	<input type="checkbox"/> Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service.	
<input type="checkbox"/> Sale of Commercially Pre-Packaged PHF's	<input type="checkbox"/> Preparation Of PHFs For Hot And Cold Holding For Single Meal Service	<input type="checkbox"/> PHF and RTE Foods Prepared For Highly Susceptible Population Facility	
<input type="checkbox"/> Delivery of Packaged PHFs	<input type="checkbox"/> Sale of Raw Animal Foods Intended to be Prepared by Consumer.	<input type="checkbox"/> Vacuum Packaging/Cook Chill	
<input type="checkbox"/> Reheating of Commercially Processed Foods For Service Within 4 Hours.	<input type="checkbox"/> Customer Self-Service	<input type="checkbox"/> Use Of Process Requiring A Variance And/OR HACCP Plan (including bare hand contact alternative, time as a public health control)	
<input type="checkbox"/> Customer Self-Service Of Non-PHF and Non-Perishable Foods Only.	<input type="checkbox"/> Ice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Offers Raw Or Undercooked Food Of Animal Origin.	
<input type="checkbox"/> Preparation Of Non-PHF's	<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Prepares Food/Single Meals for Catered Events or Institutional Food Service	
	<input type="checkbox"/> Offers RTE PHF in Bulk Quantities	<i>To be completed by the Board of Health</i>  <b>Total Permit Fee:</b> _____ <b>Payment is due with application</b>	
	<input type="checkbox"/> Retail Sale of Salvage, Out of Date or Reconditioned Food		

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  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Return to:

Wellesley Health Department  
 90 Washington St  
 Wellesley, MA 02481

**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 #: \_\_\_\_\_