



Board of Health

Town of Whitman

54 South Avenue, P.O. Box 426

Whitman, Massachusetts 02382-0426

One Day Food Permit Supplemental Sheet

1. Where is the event being held:

2. Date & Time of event: _____

3. Provide copy of food permit and inspection from primary town.

Town name _____

Date of most recent inspection _____

4. Provide copy of menu.

5. Provide copy of allergen training certificate for person working at advent in question 1.

6. Provide copy of food protection manager certificate working at advent in question 1.

7. Call Health Inspector Alexis Andrews at 781-618-9756 or 781-844-8609 to arrange inspection appointment.

8. Check payable to the Town of Whitman – BOH for \$25.00

9. Contact person information:

Name _____

Cell# _____

FOR HEALTH DEPARTMENT USE ONLY

Date Received

Date Inspected

Approved By

Permit # Issued

One Day Permit

\$ 25.00

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> </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:	Fax:												
Emergency Telephone No:													
13) District Or Regional Supervisor (if applicable)													
Name & Title:													
Address:													
Telephone No:	Fax:												

Food Establishment Information

14) Water Source: DEP Public Water Supply No: (if applicable)		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): Yes 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) <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	
21) Length Of Permit: <i>(check one)</i> <input type="checkbox"/> Annual <input type="checkbox"/> Seasonal/Dates: <input type="checkbox"/> Temporary/Dates/Time:		Other (Describe)	
23) Food Operations: <i>(check all that apply):</i>		Definitions: <i>PHF – potentially hazardous food (time/temperature controls required)</i> <i>Non-PHF – 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-PHFs	<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 PHFs	<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-PHFs	<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Prepares Food/Single Meals for Catered Events or Institutional Food Service	
Other (Describe): <input type="checkbox"/> Offers RTE PHF in Bulk Quantities <input type="checkbox"/> Retail Sale of Salvage, Out-of Date or Reconditioned Food		<i>To be completed by the Health Department</i> 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 health department 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
 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 #: _____



Board of Health

Town of Whitman

54 South Avenue, P.O. Box 426

Whitman, Massachusetts 02382-0426

TAXES PAID AFFIDAVIT

Date: _____

Type of license applying for: _____

Business name: _____

Business address: _____

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 as required under law. As of the above date, all bills for this property/business are current in the Whitman Collector's office.

*Signature of Individual

by: Corporate Officer

**Social Security Number Voluntary
Or Federal Identification Number

*This license will not be issued unless this certification clause is signed by the applicant.

Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency **will be subject to license suspension or revocation. This request is made under the authority of M.G.L. Chapter 62C, Section 49A.

Updated 10/16

Telephone: 781-618-9754

Facsimile 781-618-9798

e-mail health@whitman-ma.gov