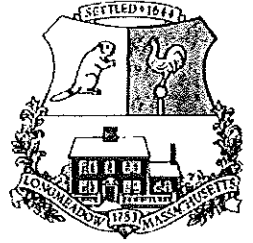


town of
LONGMEADOW, MASSACHUSETTS

phone: (413) 565-4140 20 Williams Street 01106



BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

BOARD OF HEALTH

MICHAEL COPPOLA, M.D.

BARRY IZENSTEIN, M.D.

ROBERT RAPPAPORT, D.M.D.

RICHARD STEINGART, M.D.

MARY P. TOYE, R.N., M.S.

APPLICATION FOR PERMIT TO OPERATE A BAKERY

Application is made for permit to operate a bakery in accordance with provisions of Chapter 94, Section 305A and Chapter 111, Section 5 of the General Laws.

Full name of Establishment

Business Address

Tel. No.

Type of Business

If application is a sole owner, full name and address:

If applicant is partnership, full name and address of all partners:

Is applicant a corporation? _____ State of Incorporation _____

Full name and address of:

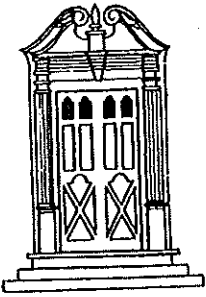
President _____

Treasurer _____

Clerk _____

Signature of person preparing application _____

Home address _____ Date _____



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LONGMEADOW BOARD OF HEALTH

STATEMENT OF YEARLY GROSS INCOME

Please check one of the following sales figures signifying the yearly gross income of your business as the basis for paying the proper Board of Health license fee/s to the Town of Longmeadow.

Type of License	Fee	Yearly Gross Income Sales
Food Service	\$195.00	\$200,000
	\$725.00	\$200,000- \$1,000,000
	\$1125.00	\$1,000,000
Retail Food	\$195.00	\$200,000
	\$725.00	\$200,000- \$1,000,000
	\$1125.00	\$1,000,000
Bakery	\$150.00	\$200,000
	\$375.00	\$200,000 - \$1,000,000
	\$725.00	\$1,000,000

Under the penalties of perjury, I do hereby certify that this form and statement is to the best of my knowledge, true, correct and complete. Information is subject to verification by the Longmeadow Board of Health.

_____ Date _____

Business Name

D/b/a (if any)

Owner of Corporate



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 www.mass.gov/dia

For Businesses Only

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

<p>Are you an employer? Check the appropriate box:</p> <p>1. <input type="checkbox"/> I am an employer with _____ employees (full and/or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]</p> <p>3. <input type="checkbox"/> 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]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p>Business Type (required):</p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
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*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.

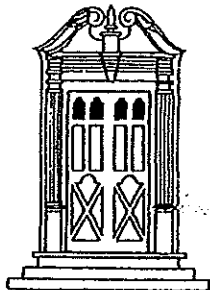
I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

<p><i>Official use only. Do not write in this area, to be completed by city or town official.</i></p>	
<p>City or Town: <u>LONGMEADOW</u></p>	<p>Permit/License # _____</p>
<p>Issuing Authority (circle one):</p> <p>1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office.</p> <p>6: Other _____</p>	
<p>Contact Person: <u>BEVERLY S. HIRSCHORN</u></p>	<p>Phone #: <u>(413) 565-4140</u></p>

For Businesses Only



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**MANDATORY CERTIFICATION FOR APPLICANTS
FOR BOARD OF HEALTH LICENSES**

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.

Signature of Individual or Corporate Name
(Mandatory)

By: Corporate Office Mandatory, if Applicable

Social Security or Federal Identification Number
(Voluntary)

Your license(s) 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 Mass G.L.C. 62C. S.49A.