

Fee: \$ 70.00



town of  
**LONGMEADOW, MASSACHUSETTS**

phone: (413) 565-4140

20 Williams Street

01106

**BOARD OF HEALTH**

BEVERLY S. HIRSCHHORN, CHO, MPH  
Health Director

MICHAEL COPPOLA, M.D.  
ALAN LEVINE, R.Ph.  
ROBERT RAPPAPORT, D.M.D.  
RICHARD STEINGART, M.D.  
MARY PAT TOYE

APPLICATION FOR *MOBILE* FOOD SERVICE ESTABLISHMENT PERMIT

Name \_\_\_\_\_

Address \_\_\_\_\_ Phone No \_\_\_\_\_

Menu \_\_\_\_\_

Source of Food

A. Where prepared \_\_\_\_\_

B. By Whom \_\_\_\_\_

Food Protection

A. How will hot foods be maintained at safe temps? (150 or above)

En route \_\_\_\_\_

At site \_\_\_\_\_

B. How will cold foods (perishable) be maintained at safe temps?

En route \_\_\_\_\_

At site \_\_\_\_\_

C. Type of structure for food service and preparation

Tent \_\_\_\_\_ Mobile Unit \_\_\_\_\_ Enclosed area \_\_\_\_\_ Other \_\_\_\_\_

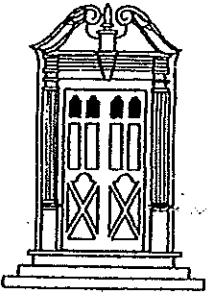
Signature \_\_\_\_\_ Date \_\_\_\_\_

For Businesses Only

*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 IZENSBERG, M.D.
- ROBERT RAPPAPORT, D.M.D.
- RICHARD STEINGART, M.D.
- MARY P. TOYE, R.N., M.S.

**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.**

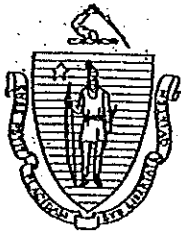
\_\_\_\_\_  
Signature of Individual or Corporate Name  
(Mandatory)

\_\_\_\_\_  
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.



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

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: LONGHEAD W

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: BEVERLY S. HIRSCHHORN

Phone #: (413) 565-4140