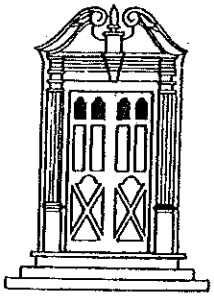
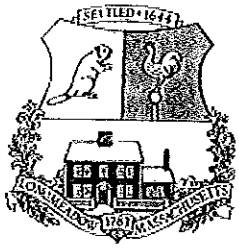


FEES: $45.00/1-DAY
$ 75.00/2-DAY

town of

LONGMEADOW, MASSACHUSETTS

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



BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

APPLICATION FOR A TEMPORARY FOOD SERVICE ESTABLISHMENT PERMIT

Name _____

Address _____ Tel. No. _____

Place _____ Date _____

Menu _____

_____

Source of Food

A. Where prepared

_____

B. By Whom

_____

Food Protection

A. How will hot foods be maintained at safe temp? (150 or above)
En route _____

At site _____

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

En route _____

At site _____

C. Type structure for food service and preparation
Tent _____ Mobile Unit _____ Enclosed area _____ Other _____

THE ABOVE INFORMATION IS REQUIRED TO BE SUBMITTED, IN ACCODANCE WITH REGULATION 20 OF ARTICLE X OF THE STATE SANITARY CODE. THIS PERMIT IS VALID ONLY FOR THE DATE OR DATES SPECIFIED, AND IN NO CASE TO BE VALID FOR OVER FOURTEEN DAYS.

Signature _____ Date _____

For Businesses Only

town of

LONGMEADOW, MASSACHUSETTS

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

BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

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: LONGMEADOW **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