town of

LONGMEADOW, MASSACHUSETTS

20 Williams Street 01106
phone: 413-565-4140 fax:413-565-4371

Finn McCool
Health Director

BOARD OF HEALTH
Dr. Robert Baevsky, Chair
Dr. Richard Steingart, Vice Chair
Dr. Anastaios Angelides, Clerk
Dr. Gregory Valania
Dr. Michele Keane-Moore
Dr. Elliot Greenberg, Assoc. Member

APPLICATION FOR A TEMPORARY FOOD SERVICE ESTABLISHMENT PERMIT

Name: _____

Address: _____**Tel No.:** _____

Place of Event: _____ **Date of Event:** _____

Menu: _____

_____

Source of Food

Where Prepared:

_____

By Whom:

_____

Food Protection

How will hot foods be maintained at a safe temp? (150 degrees or above)
En Route: _____

At Site: _____

How will cold foods (perishable) be maintained at sage temps?
En Route: _____

At Site: _____

Type structure for food service and preparation
Tent _____ **Mobile Unit** _____ **Enclosed Area** _____ **Other** _____

THE ABOVE INFORMATION IS REQUIRED TO BE SUBMITTED, IN ACCORADANCE 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:** _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette
Boston, MA 02111-1750
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

Are you an employer? Check the appropriate box:

1. ☐ I am an 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 _____

**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 § 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 (check one):

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board
5. Selectmen's Office 6. Other _____
Contact Person: _____Phone #: _____

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MANDATORY CERTIFICATION FOR APPLICANTS

FOR BOARD OF HEALTH LICENSES

I certify under the penalties of perjury, I do to the best of my 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.