



Town of Abington

OFFICE OF
BOARD OF HEALTH
500 GLINIEWICZ WAY
ABINGTON, MA 02351
TEL.: (781) 982-2119 · FAX: (781) 982-2127
www.abingtonma.gov

Office use only
Date received: _____
Amount paid: _____
Check number: _____
Permit number: _____
Received by: _____

FOOD ESTABLISHMENT PERMIT APPLICATION

- 1) Establishment Name: _____
- 2) Establishment Address: _____
- 3) Establishment Mailing Address (if different): _____
- 4) Establishment Telephone Number: _____
- 5) Applicant Name & Title: _____
- 6) Applicant Address: _____
- 7) Applicant Telephone Number: _____ 24 Hour Emergency Number: _____
- 8) Owner Name & Title (if different from applicant): _____
- 9) Owner Address (if different from applicant): _____

<p>10) Establishment Owned by:</p> <p><input type="checkbox"/> An association</p> <p><input type="checkbox"/> A corporation</p> <p><input type="checkbox"/> An individual</p> <p><input type="checkbox"/> A partnership</p> <p><input type="checkbox"/> Other legal entity _____</p>	<p>11) If a corporation or partnership, give name, title, and home address of officers or partner.</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; border-bottom: 1px solid black;">Name</th> <th style="text-align: left; border-bottom: 1px solid black;">Title</th> <th style="text-align: left; border-bottom: 1px solid black;">Home Address</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> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Title	Home Address												
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12) Establishment Type (check all that apply):

- | | | | |
|---|-------|--|-------|
| <input type="checkbox"/> Retail Food | \$200 | <input type="checkbox"/> Food Establishment..... 0-25 seats | \$175 |
| <input type="checkbox"/> Mobile Food..... Annual | \$125 | <input type="checkbox"/> 26-50 seats | \$200 |
| <input type="checkbox"/> Seasonal | \$75 | <input type="checkbox"/> 51-75 seats | \$225 |
| <input type="checkbox"/> Catering..... Annual | \$100 | <input type="checkbox"/>76 + seats | \$250 |
| <input type="checkbox"/> Per event | \$50 | <input type="checkbox"/> Frozen Dessert Machine | \$20 |
| <input type="checkbox"/> Temporary Food (per event) | \$50 | <input type="checkbox"/> Bottling of Non-alcoholic Beverages | \$50 |
| <input type="checkbox"/> Farmers Market (per event) | \$50 | <input type="checkbox"/> Bakery | \$100 |
| <input type="checkbox"/> Residential Kitchen | \$75 | <input type="checkbox"/> House of Worship Kitchen | \$100 |

Note: LATE applications will be charged DOUBLE the fee.

TOTAL AMOUNT DUE: \$ _____

**MAKE CHECK PAYABLE TO: TOWN OF ABINGTON
PAYMENT DUE WITH APPLICATION — NO CASH CAN BE ACCEPTED.**

13) Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager, etc.):

Name & Title: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Emergency Number: _____

14) District or Regional Supervisor (if applicable):

Name & Title: _____

Address: _____

Telephone Number: _____ Fax Number: _____

Food Establishment Information

15) Name of Person in Charge Certified in Food Protection Management: _____
Local Board of Health Regulation states that a Certified Food Protection Manager must be on site during all shifts. (Please attach copies of all certificates)

16) Allergen Awareness: (applies to “all food establishments that cook, prepare, or serve food intended for immediate consumption either on or off the premises.”)

Food allergen poster and menu advisory requirements in place (check one): Yes No
Required as of 10/1/2010 in accordance with 105 CMR 590.009(H)

Food Allergen Awareness Training Certificate obtained (check one): Yes No
Required as of 2/1/2011 in accordance with 105 CMR 590.009(H) (Please attach copy of certificate)

17) Water Source: _____ **18) Sewage Disposal:** _____
DEP Public Water Supply No. (if applicable): _____

18) Days and Hours of Operation: _____ **20) No. of Food Employees:** _____

19) Person Trained in Anti-Choking Procedures (if 25 seats or more): Yes No

20) Location (check one): Permanent Structure Mobile

21) Length of Permit (check one): Annual Seasonal Dates: _____ Temporary/Dates/Time: _____

22) Restaurant/Food Service: Total # of Seats _____

23) Mobile Food Units/Pushcart: Application for mobile food units or pushcarts must include a list of handwash and toilet facilities available on each route. Attach a separate sheet.

24) Extermination – Frequency of Service (check one): Weekly Bi-Monthly Monthly
Contractor’s Name _____ Telephone # _____

25) Rubbish/Garbage Collection – Frequency of Service (check one): Daily Bi-Weekly Weekly Bi Monthly Monthly
Private Collection: Contractor’s Name _____ Telephone # _____
Address _____

26) Dumpster on Location (check one): Yes No
Dumpster lid must be closed at all times – locked if necessary. Dumpster/Storage area to be kept clean at all times.

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 Board of Health on how to obtain copies of 105 CMR 590.000 and the Federal Food Code.

27) 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.

28) Social Security Number or Federal ID: _____

29) Signature of Individual or Corporate Name: _____