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) **Applicant E-mail:**_____
9) **Owner Name & Title** (if different from applicant):_____

10) Establishment Owned by:

- ❑ An association
- ❑ A corporation
- ❑ An individual
- ❑ A partnership
- ❑ Other legal entity _____

11) If a corporation or partnership, give name, title, and home address of officers or partner.

Name	Title	Home Address

12) Establishment Type (check all that apply):

❑	Retail Food	$200	❑	Food Establishment..... 0-25 seats	$175
❑	Mobile Food..... Annual	$125	❑	..... 26-50 seats	$200
❑	..... Seasonal	$75	❑	..... 51-75 seats	$225
❑	Catering..... Annual	$100	❑	.....76 + seats	$250
❑	..... Per event	$50	❑	Frozen Dessert Machine	$20
❑	Temporary Food (per event)	$50	❑	Bottling of Non-alcoholic Beverages	$50
❑	Farmers Market (per event)	$50	❑	Bakery	$100
❑	Residential Kitchen	$75	❑	House of Worship Kitchen	$100
❑	Juice Manufacturing	$100			

Note: LATE applications will be charged DOUBLE the fee.

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: _____