

FEE:

OFFICE OF THE
BOARD OF HEALTH
13 East Central St., Natick MA 01760

Telephone 508-647-6460
Fax 508-647-6466

APPLICATION TO OPERATE A FOOD ESTABLISHMENT

Today's Date: _____

Name of Establishment: _____

Location Address: _____ **NATICK MA**

Mailing Address:
(if different than above) _____

Telephone # at Establishment _____

Email Address _____

Name & Title of Applicant _____

Address of Applicant: _____

Name of Owner (if different from applicant) _____

Type of Ownership: (circle one)

A Individual *B Partnership *C Corporation *D Association *E Other explain _____

* if B, C, D, or E circled - provide Name, Title, Phone # and Home Address of Officers or Partners

Name Title Telephone # Home Address

Emergency Response Person or Zone, District, Regional Manager:

Name: _____ Telephone Number: _____

Address: _____ Email: _____

Manager of Food Establishment:

Name: _____ Telephone Number: _____

Address: _____ Email: _____

OVER

Type of Food Establishment - check all that apply

- | | |
|---|---|
| <input type="checkbox"/> Food Service | <input type="checkbox"/> Caterer |
| <input type="checkbox"/> Retail Food | <input type="checkbox"/> Cottage Operation |
| <input type="checkbox"/> Incidental Retail Food
(pre-packaged, non-refrigerated foods only) | <input type="checkbox"/> Incubator Kitchen |
| <input type="checkbox"/> Mobile <i>complete unit information sheet and other
permitting procedures as requested</i> | <input type="checkbox"/> Incubator/Shared Kitchen Participant |
| | <input type="checkbox"/> Institutional ex. School, Nursing Home, Day Care |
| | <input type="checkbox"/> Private Club, Church, Non Profit |

Duration of Permit: Annual Seasonal *Temporary Event *must list all food and where it is from*

Day(s) and Hours of Operation / Temporary Event: _____

Seating Capacity: _____ **Square Footage (for Retail):** _____

*Temporary Event *must list the food to be served and where it is from; use an additional page if necessary*

Person(s) Certified in:	Yes	No
Food Safety Management		
Allergen Awareness		
Anti-Choking Procedures <i>services with seating capacity of 25 or more must have a certified employee on site for each shift</i>		
<u>All applicable certifications shall be posted in a conspicuous place</u>		

By signing this I attest to the accuracy of the information provided in this application. Furthermore I affirm compliance with the provisions of 105CMR 590.000/Federal Food Code and allow the regulatory authority access to the establishment as specified in this Code.

Signature of Applicant _____

Pursuant to M.G.L. Ch 62C, section 49A, 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.

Social Security # or Federal ID #

Signature of Individual or Corporate Name

Signature of Corporate Officer (if applicable)

Please make checks payable to the **Town of Natick** and return to
The Board of Health, 13 East Central St., Natick, MA 01760