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| FOR BOARD OF HEALTH USE ONLY **Date Received date inspected Approved by PERMIT Fee: $\_\_\_\_\_\_\_\_\_\_\_ PERMIT ISSUED** LATE FEE: $\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_ **TOTAL FEE = $\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_**  |

#### TOWN OF FAIRHAVEN

**BOARD OF HEALTH**

40 Center St. - Fairhaven, MA 02719 - Telephone (508) 979-4023 Ext. 125

**Mobile Food Permit Application**

**PLEASE *PRINT* CLEARLY TODAY’S DATE:**

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| **1) Establishment Trade Name:**  |
| **2) Establishment Address:** |
| **3) Establishment Mailing Address (*if different*):** |
| **4) Establishment Telephone No.: ( ) Fax No.**: **( )** |
| **5) Applicant Name: Applicant’s Title:** |
| **6) Applicant Address: TELEPHONE No.: ( )** |
| **7) Establishment Owner’s Name: (First)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Last)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MI)\_\_\_**  **Association, Corporation, Partnership, Legal Entity Name:**  |
| **8) Owner’s Address (*if different from applicant*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Owner’s E-Mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 9) Food Establishment isOWNED by: (*Check one*)Association Corporation Individual Partnership Other Legal Entity | 10) If owned by a corporation or a partnership, give name, title and home address of officers or partner(s) as registered with the Secretary of State *(Please provide an attachment if necessary)*: **Officer/Partner’s Name Title Home Address****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****(First) (Last) (MI)** |
| **11) Establishment is:** **(*Check one*)** Part of Chain  Independent |
| **12) Person Directly Responsible for Daily Operations *(Owner, Person in Charge, Supervisor, Manager etc.):***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax No.: ( ) **24 Hour Emergency Number: ( )** |
| **13) District or Regional Supervisor *(if applicable):***Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No.: ( ) **24 Emergency Number: ( )** |
| **14) Style of Establishment: *(Check only one)*** Bar Gas Station Only Liquor Store Restaurant (Bar Area) Convenience Store Gas Mini-Mart Membership Association Restaurant Only Department Store Grocery Store Pharmacy/Retail Store Other (specify): |

Food Establishment Information (continued)

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| **15) Water Source:** | **16) Sewage disposal:** |
| **17) Days and Hours of Operation:** | **18) Number of Food Employees:** |
| **19) Name of Person(s) in Charge Certified in Food Protection Management & Food Allergens Notice: *(Attach copy of certificates*):** |
| **20) Person Trained in Anti-Choking Procedures *(if 25 seats or more*):**  **Yes** **No (*Attach copy of certificate*)** |
| **21) Establishment Type: *(Check all that apply)*** Retail (\_\_\_\_\_\_\_\_\_\_\_\_ Sq. Ft.)  *Residential Kitchen* *for:*  Caterer  Food Service - (\_\_\_\_\_\_\_\_\_ Seats) Retail Sale Food Delivery  Food Service – Takeout Bed & Breakfast Home Mobile Vehicle Food Service – Institution(\_\_\_\_\_Meals/D ) Bed & Breakfast Establishment Push Cart Frozen Dessert Manufacturer Other *(Describe)*: |
| **22) Location Type: *(Check one)***  Permanent Structure Temporary Structure Mobile Unit |
| **23) Length of Permit: (*Check one*)** Annual Seasonal - Dates: Temporary - Dates:Times:  |
| **24) Food Preparation: *(Check all that apply)*****Definitions: PHF – potentially hazardous food (time/temperature controls required)** **Non-PHFs – non-potentially hazardous food (no time/temperature controls required)** **RTE – ready-to-eat foods (eg. sandwiches, salads, muffins which need no further processing)** |
|  Sale of commercially pre-packaged  Non-PHFs  Sale of commercially pre-packaged PHFs Delivery of packaged PHFs  Reheating of commercially processed foods for service within (4) hours Customer self-service of Non-PHF and non-perishable foods only Preparation of Non-PHFs for retail sale Offers RTE PHF in bulk quantities PHF cooked to order  Preparation of PHFs for hot and cold  holding for single meal service  |  Customer self service Sale of raw animal foods intended to be prepared by consumer Ice manufactured and packaged for retail sale Juice manufactured and packagedRetail sale of salvage, out-of-date or reconditioned food Hot PHF cooked and cooled or hot held for more than a single meal service PHF and RTE foods prepared for  highly susceptible population facility Raw or undercooked food of animal  origin  |  Vacuum packaging/cook chill Use of process requiring a variance  and/or HACCP Plan (including bare  hand contact alternative, time as a  public health control)  Prepared food/single meals for catered events or institutional food service Other *(Describe*): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **If applicable, Name of** **Dumpster Company:** **Pick up dates:** **Grease Hauler**:  **Pick up dates:**  **Septic hauler:**   |
| **Reminder: Consistent with M.G.L. Ch.270, Section 22 and per order of the Fairhaven Board of Health, Food Establishments must prohibit smoking on the premises at all times and post smoke-free notices at all points of entry, restrooms, and conspicuously upon the premises. It shall be the responsibility of the permit holder or his/her Business Agent to prohibit smoking on the premises.**  |

25) Enter Establishment Owner’s Tax Identification Number as reported to Massachusetts Department of Revenue:

***✓*  *If owned by an individual:* Social Security Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***✓ If owned by an association, corporation, partnership, or other legal entity:***

 **Federal Identification Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pursuant to MGL c. 62C, sec. 49A, I certify under the penalties of perjury that the owner (s) of this establishment, to the best of my knowledge and belief, have filed all applicable tax returns and paid all taxes required under law. I, the undersigned, attest to the accuracy of the information provided in this application, and affirm that this food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the Fairhaven Board of Health Administrative Office on how to obtain copies of 105 CMR 590.000 and the Federal Food Code.

**26) Authorized Signatory –*print* name and title clearly and *sign* below:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Payment is due with application*