

**DIVISION OF HEALTH INSPECTIONS  
PROCEDURES FOR APPLYING FOR A HEALTH PERMIT**

**PLAN REVIEW PROCEDURES (for establishments being constructed)  
(BY APPOINTMENT ONLY)**

1. Complete a Health Division Application
2. Pay Health Division fees
3. Have four (4) sets of plans
4. Submit one (1) copy of all new equipment specification forms from manufacturer w/NSF/UL approval. NSF standard #7 for refrigeration
5. Complete and submit a Food Plan Review Worksheet
6. Submit one (1) copy of menu w/consumer advisory (if appropriate)
7. Submit signed plans to the Building Division with Building Permit applications and appropriate fees
8. Building permit must be signed off by inspectors
9. Proceed to next session

**APPLYING FOR A PERMIT  
(APPLICATIONS ARE ACCEPCTED IN PERSON ONLY)**

1. Apply/obtain the appropriate Certificate of Occupancy and/or Certificate of Inspection from Building Division
2. Bring copy of Certificate of Occupancy and Certificate of Inspection to the Health Division
3. Complete the Health Division application
4. Submit a copy of the Fulltime onsite Food Manager Certification and Allergen Awareness Certification
5. Submit common Victuallers License (for Restaurant only)
6. Pay Health Fees and request a "Pre-Opening inspection from the Health Division



# BOSTON INSPECTIONAL SERVICES DEPARTMENT

## DIVISION OF HEALTH INSPECTIONS

1010 MASSACHUSETTS AVE.

BOSTON, MA 02118

Tel (617) 635-5326 Fax (617) 635-5388

### FOR BOARD OF HEALTH USE ONLY

Date Received

Date Inspected

Approved By

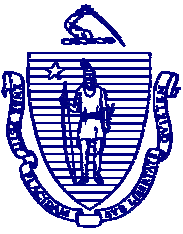
Permit # Issued

Fee

## Food Establishment Permit Application

<b>1) Establishment Name:</b>	
<b>2) Establishment Address:</b>	
<b>3) Establishment Mailing Address (if different):</b>	
<b>4) Establishment Telephone No:</b>	
<b>5) Applicant Name and Title:</b>	
<b>6) Applicant Address:</b>	
<b>7) Applicant Telephone No:</b>	
<b>8) Owner Name and Title (if different from applicant):</b>	
<b>9) Owner Address (if different from applicant):</b>	
<b>10) Establishment Owned By:</b>  <input type="checkbox"/> An association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A partnership <input type="checkbox"/> Other Legal entity _____	<b>11) If a corporation or partnership, give name, title and home address of officers or partners:</b> <u>Name:</u> _____ <u>Title:</u> _____ <u>Address:</u> _____ _____ _____ _____ _____
<b>12) Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.)</b>	
Name & Title :	
Address:	
Telephone No:	Fax:
Emergency Telephone No:	
<b>13) District Or Regional Supervisor (if applicable )</b>	
Name & Title :	
Address:	
Telephone No:	Fax:





The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 600 Washington Street  
 Boston, MA 02111  
 www.mass.gov/dia

**Workers' Compensation Insurance Affidavit: General Businesses**

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- 1.  I am a 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 \_\_\_\_\_

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

\*\*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 Section 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 (circle one):**

- 1. Board of Health
- 2. Building Department
- 3. City/Town Clerk
- 4. Licensing Board
- 5. Selectmen's Office
- 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_



BOSTON INSPECTORIAL SERVICES DEPARTMENT  
1010 MASSACHUSETTS AVENUE  
BOSTON, MA. 02118  
(617) 635-5326

APPLICATION FOR A PERMIT TO OPERATE A MOBILE FOOD VEHICLE OR PUSHCART  
ANSWER ALL QUESTIONS IF NOT APPLICABLE WRITE N/A

CIRCLE ALL WHICH APPLY TO YOUR BUSINESS  
VEHICLE (S) # \_\_\_ PUSHCART (S) # \_\_\_

SELL: FROZEN DESSERT/YOGURT/ICE CREAM/ OR MILK  
MANUFACTURING: FROZEN DESSERT/YOGURT/ICE CREAM (SOFT SERVE)

NAME OF VEHICLE/PUSHCART \_\_\_\_\_

BASE OF OPERATION \_\_\_\_\_  
STREET CITY STATE & ZIP

VERIFICATION LETTER FROM LICENSED COMMISSARY OR ESTABLISHMENT YES \_\_\_ NO \_\_\_

NAME OF OWNER \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_  
STREET CITY STATE & ZIP

BUSINESS PHONE NUMBER \_\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_

SIGNATURE OF OWNER \_\_\_\_\_ SSI# OR FEDERAL I. D. \_\_\_\_\_

EMERGENCY RESPONSE PERSON \_\_\_\_\_ PHONE # \_\_\_\_\_

**LOCATION IN THE CITY (BE SPECIFIC)**

<b>STREET NAMES &amp; SECTION OF THE CITY</b>	<b>DAYS AND TIMES</b>
_____	_____
_____	_____
_____	_____

HANDWASHING AND TOILET FACILITIES ARE AVAILABLE AT \_\_\_\_\_

<b>FOOD PRODUCTS TO BE SOLD</b>	<b>SOURCE OF FOOD PRODUCTS</b>
_____	_____
_____	_____
_____	_____

MAKE & YEAR OF VEHICLE \_\_\_\_\_ STATE OF REGISTRATION \_\_\_\_\_ REGISTRATION # \_\_\_\_\_

**IF YOU ARE A CORPORATION OR PARTNERSHIP, PLEASE COMPLETE THE FOLLOWING:**

NAME & TITLE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

NAME & TITLE \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

DAYS AND HOURS OF OPERATION \_\_\_\_\_

**IF YOU MANUFACTURE FROZEN DESSERT/ICE CREAM PLEASE COMPLETE THE FOLLOWING:**

WHOM IS THE MIX PURCHASED FROM/NAME OF COMPANY \_\_\_\_\_

IS THE MIX PASTEURIZED? YES \_\_\_ NO \_\_\_ NUMBER OF REFRIGERATORS/FREEZERS \_\_\_\_\_

ARE YOU AWARE OF THE REGULATIONS REGARDING THE SUBMISSION OF MONTHLY LAB REPORTS? YES \_\_\_ NO \_\_\_