BATH ESTABLISHMENT

To obtain a license from the Boston Inspectional Services Department, Division of Health Inspections, you must provide the following:

1. Proof of authority to do business in Massachusetts, (Boston Business Certificate and/or Article of Incorporation or Partnership).

2. Two passport size photographs (2” x 2”) of applicant.

3. Written proof of age (birth certificate, driver’s license, and passport).


5. New establishments must provide 4 copies plan and request an appointment for review by contacting the office directly and speaking with a supervisor at 617-635-5326.

6. Complete a Health Division application. The CORI application must be completed. Applications are accepted Monday through Friday, 8:00 am – 3:30 pm. All required documents must be submitted with completed application.

7. Bath establishment license fee is $200.00 annually.
Applicant’s Full Name: _____________________________ Date: ___________________________

Home Address: ________________________________________________________________

No.  Street   Town/City  State  Zip

Home Phone No: ___________________________ Business Phone No: ___________________________

Business Name: ________________________________________________________________

Business Address: ________________________________________________________________

No.  Street   Town/City  State  Zip

If a corporation or partnership, please give name, title and home address of officers, partnerships, stockholders with 10% or more of the stock.

Name of Corporation or Partnership ______________________________________________

Name/Title: ___________________________

Home Address/Phone No.: __________________________________________________________

Name/Title: ___________________________

Home Address/Phone No.: __________________________________________________________

Name/Title: ___________________________

Home Address/Phone No.: __________________________________________________________

State of Incorporation: ___________________________ Tax Number ___________________________
Articles of incorporation or partnership submitted:  Yes _____ No _____

Boston Business Certificate submitted:  Yes _____ No _____

Zoning/Building Department approval:  Yes _____ No _____

All residential addresses of applicant for the past five (5) years:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

D.O.B _______ Age _____ Sex _____ Height _____ Weight _____ Hair Color _______ Eye Color _______

Two (2) photographs 2" x 2" of applicant must be submitted  Yes _____ No _____

Former occupations of applicant for past three (3) years:

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Name of business &amp; address</th>
<th>Bath Experience</th>
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<tbody>
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List all criminal convictions, forfeiture of bond, or plea of nolo contendere, excluding traffic, misdemeanor or infraction violations:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Have you had any license or permit suspended or revoked by any agency or board, city, county or state?  Yes ____ No ____

If yes, explain:  ___________________________________________________________

________________________________________________________________________

I authorize and release the Department to seek information or references necessary to verify the information contained in this application:

________________________________________________________________________

Signature of Applicant ___________________________________ Social Security Number

I certify under penalty of perjury that all information contained in the application is true and correct. Any misstatements in this application are grounds for refusing to issue or for revocation of any license issued.

Signature of Applicant ___________________________________ Social Security Number
Boston Inspectional Services Department
Division of Health Inspections
1010 Massachusetts Avenue
Boston, MA 02118
Tel: 617-635-5326
Fax: 617-635-5388

CORI REQUEST FORM

Boston Inspectional Services has been certified by the Criminal History Systems Board for access to conviction and pending criminal case data. As an applicant/employee for ____________________, I understand that a criminal record check will be conducted for conviction and pending criminal case information only and that it will not necessarily disqualify me. The information below is correct to the best of my knowledge.

__________________________
Applicant/Employee Signature

LAST NAME ________________ FIRST NAME ________________ MIDDLE NAME ________________

MAIDEN NAME OR ALIAS (IF APPLICABLE) ________________ PLACE OF BIRTH ________________

DATE OF BIRTH: ________________ LAST 6 DIGITS OF SOCIAL SECURITY #: ___ - ___

FATHER’S NAME: ________________________________ (FIRST) ________________________________ (LAST)

MOTHER’S MAIDEN NAME: ________________________________ (FIRST) ________________________________ (LAST)

CURRENT AND FORMER ADDRESSES:

____________________________________________________

____________________________________________________

____________________________________________________

SEX: _____ RACE: ______

STATE DRIVER’S LICENSE NUMBER: ________________________________

*THE INFORMATION WAS VERIFIED WITH THE FOLLOWING FORM OF GOVERNMENT ISSUED PHOTOGRAPHIC IDENTIFICATION: ________________________________

REQUESTED BY: ________________________________

SIGNATURE OF CORI AUTHORIZED EMPLOYEE
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, §(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.]

*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.

Insurer's Address: ______________________________________

City/State/Zip: ____________________________ Expiration Date: __________

Policy # or Self-ins. Lic. # ____________________________

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):

Contact Person: ____________________________ Phone #: ____________________________
DIVISION OF HEALTH INSPECTIONS PROCEDURES FOR OBTAINING A MOBILE PERMIT
(PLEASE READ CAREFULLY AND IF YOU ARE UNSURE PLEASE INQUIRE)

In order to obtain a Mobile Food Health Permit from the Inspectional Services Department the following documents must be submitted prior to the inspection. Inspections CANNOT be performed if information is incomplete and not submitted prior to inspection.

If you are vending in the City of Boston you may have to go to Police Headquarters, 1 Schroeder Plaza Boston, MA 02120, 617-343-4425, to verify where you can sell. (SOME AREAS ARE RESTRICTED)

If you are a mobile food walk on truck you are required to contact Edith Murane Boston City Hall, 1 City Hall Plaza, Rm. 603, Boston, MA, 02201. 617-635-1456

If you are at a permanent location, you must obtain a Hawkers and Peddlers license from the Division of Standards, One Ashburton Place, Rm. 1115, Boston, MA 02108. 617-727-3480

If you are vending on a public property, you must obtain a permit from the Department of Public Works, Anne McNeil, 1 City Hall Plaza, Rm. 714, Boston, MA, 02201 617-635-4911.

If you are vending on private property, you must obtain a Use of Premises permit from the Inspectional Services Department, Building Division, 1010 Mass. Ave, 5th Fl., Boston, MA 02118. 617-635-5300.

If you are vending in a city park, you must obtain a permit from the Parks & Recreational Department, 1010 Mass. Ave, 3rd Fl., Boston, MA 02118. 617-635-4505.

You are required to obtain a copy of the Massachusetts Sanitary Code 105CMR 590.000 and the 1999 Federal Food Code. These can be obtained at the State House Bookstore, RM 116, and 617-727-2834.

New mobile food units must submit plans for approval by the Health Division before you obtain a Health Permit. Plans are reviewed by appointment only. You can do this by calling Thomas Coffill at 617-961-3219.

All mobile food units or pushcarts shall operate from a fixed licensed food establishment and shall report twice daily to such location for all food and supplies and for all cleaning and sanitizing units and equipment. You must provide a letter on their letterhead stating you have permission to perform these duties from their establishment along with a copy of their permit.

If you sell potentially hazardous foods, you are required to have a full time on site certified food protection manager assigned to the mobile food operation. Please ask for course package. These courses are not offered by the City of Boston but through private consultants.

You must complete a Health Division application and provide the required documents and licenses at the time of your inspection. Inspections are performed at 1010 Massachusetts Ave, Monday – Friday from 8am – 9:30am. Mobile Food permits fees are $100 per unit and $30 each if you sell milk or ice cream. If you manufacture frozen dessert from a soft serve machine, the fee is $100. You are also be required to have a lab that will test your machines once a month and submit those reports to the Health Division. No application will be excepted if the Tax ID # is blank.

If you are using propane, generators or open flame you are required to contact Boston Fire Department, 1010 Mass. Ave. Boston, MA 02118. Ask to speak with Lt. Martin Fernandes or Lt. Michael Kenney, Special Hazards Division, 617-343-3447, to see if a fire inspection and/or permit are needed. If you have an exhaust system you are required to contact Ross Josie, Fire Marshall’s Office at 617-343-2019.
Food Establishment Permit Application

1) Establishment Name:

2) Establishment Address:

3) Establishment Mailing Address (if different):

4) Establishment Telephone No:

5) Applicant Name and Title:

6) Applicant Address:

7) Applicant Telephone No:

8) Owner Name and Title (if different from applicant):

9) Owner Address (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 partners:

   Name: ____________________  Title: ____________________  Address: ____________________
   ____________________
   ____________________
   ____________________

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

   Name & Title: ____________________
   Address: ____________________
   Telephone No: ____________________  Fax: ____________________
   Emergency Telephone No: ____________________

13) District Or Regional Supervisor (if applicable)

   Name & Title: ____________________
   Address: ____________________
   Telephone No: ____________________  Fax: ____________________
14) Source of Water
Sewage Disposal

15) Rubbish Disposal Co.
Rendering Co. (For Grease)

16) Days and Hours of Operation:

17) No. of Food Employees

18) Name of Person In Charge Certified in Food Protection Management:
Required as of 10/1/2001 in accordance with 105 CMR 590.003(d). Please attach copy of certificate.

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

20) Location:
(choose one)
☐ Permanent Structure
☐ Mobile
☐ Other
Reg. #: __________________________
Base of Operation:

21) Establishment Type (check all that apply)
☐ Retail ( sq. ft.) ☐ Caterer
☐ Food Service ( Seats) ☐ Food Delivery
☐ Food Service-Takeout ☐ Residential Kitchen for Retail Sale
☐ Food Service-Institution ( Meals/Day) ☐ Residential Kitchen for Bed and Breakfast Home
☐ Other (Describe):

22) Length of Permit:
(choose one)
☐ Annual ☐ Residential Kitchen for Bed and Breakfast Estab.
☐ Seasonal/Dates ☐ Frozen Dessert Manufacturer
☐ Temporary/Dates/Time

23) Food Operations:
(choose all that apply): Definitions: PHF-potentially hazardous food (time/temperatures controls required)
Non-PHF's-non-potentially hazardous food (no time/temperature controls required)
RTE-ready-to-eat foods (Ex. Sandwiches, salads, muffins which need no further processing)

☐ Commercially Pre-Packaged PHFs
☐ Commercially Pre-Packaged Non-PHF's
☐ Preparation of Non-PHFs
☐ Reheats Commercially Processed Food for service within 4 hours
☐ Customer Self-Service Of Non-PHF and Non-Perishable Foods Only
☐ Delivers Food Within 1 Hour of Preparation
☐ Other (Describe):
☐ PHF Cooked To Order
☐ Preparation of PHF's For Hot And Cold Holding For Single Meal Service
☐ Sale of Raw Animal Foods Intended to be Prepared by Consumer
☐ Customer Self-Service
☐ Ice Manufactured and Packaged for Retail Sale
☐ Juice Manufactured and Packaged for Retail Sale
☐ Offers RTE PHF in Bulk Quantities
☐ Offers RTE PHF in Bulk Quantities
☐ Retail 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
☐ Vacuum Packaging/Cook Chill
☐ Use Of Process Requiring a Variance and/or HAACP Plan
☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service
☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service

1, 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 1999 Food Code.

24) 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.

25) Federal ID: ______________________________________

26) Signature of Individual or Corporate Name: ______________________________________
ANSWER ALL QUESTIONS IF NOT APPLICABLE WRITE N/A

CIRCLE ALL WHICH APPLY TO YOUR BUSINESS:

CANTEEN TRUCK    MOBILE KITCHEN    PUSHCART    ICE CREAM TRUCK    OTHER

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

LOCATION IN THE CITY (BE SPECIFIC)

# STREET NAMES & SECTION OF THE CITY

DAYS AND TIMES

HANDWASHING SINK ON MOBILE UNIT    Y/N
TOILET FACILITIES ARE AVAILABLE AT

FOOD PRODUCTS TO BE SOLD SOURCE OF FOOD PRODUCTS

HOT FOOD ITEMS (Be Specific)

COLD FOOD ITEMS (Be Specific)

MECHANICAL REFRIGERATION Y/N

MAKE & YEAR OF VEHICLE

STATE OF REGISTRATION

REGISTRATION #

IF YOU MANUFACTURE FROZEN DESSERT/ICE CREAM PLEASE COMPLETE THE FOLLOWING:
WHERE 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?    Y/N

PAGE 3
Applicant Information

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):

Contact Person: __________________________ Phone #: __________________________

www.mass.gov/dia