Inspectional Services

Martin J. Walsh, Mayor

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)**.

4. Zoning clearance **(Certificate of Occupancy)** Boston Inspectional Services, Zoning Division.

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.

City of Boston
Boston Inspectional Services Department
Health Division
1010 Massachusetts Avenue
Boston, MA 02118
Tel: (617) 635-5326
Fax: (617) 635-5388

APPLICATION FOR: BATH ESTABLISHMENT _____

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:

Occupation Name of business & address Bath Experience

_____

_____

_____

List all **criminal convictions, forefeiture 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 PHOTOGRAHIC IDENTIFICATION: _____

REQUESTED BY: _____
SIGNATURE OF CORI AUTHORIZED EMPLOYEE

BINSS
G

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 #: _____

Inspectional Services

Martin J. Walsh, Mayor

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, 1City Hall Plaza, Rm. 603, Boston, MA, 02201. 617- 635-1456

If you are not 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 Marshal's Office at 617-343-2019.

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

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:	**11) If a corporation or partnership, give name, title and home address of officers or partners:**
☐ An association ☐ A corporation ☐ An individual ☐ A partnership ☐ Other Legal entity _____	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(4). Please attach copy of certificate.*	
19) Person Trained In Anti-Choking Procedures (if 25 seats or more): ☐ Yes ☐ No	

20) Location:

(check one)

☐ Permanent Structure

☐ Mobile

Reg.#: _____

Base of Operation:

21) Establishment Type *(check all that apply)*

☐ Retail (sq.ft)

☐ Food Service (Seats)

☐ Food Service-Takeout

☐ Food Service-Institution

(Meals/Day)

(Beds)

☐ Caterer

☐ Food Delivery

☐ Residential Kitchen for Retail Sale

☐ Residential Kitchen for Bed and Breakfast Home

☐ Residential Kitchen for Bed and Breakfast Estab.

☐ Frozen Dessert Manufacturer

Other *(Describe)*: _____

22) Length of Permit:

(check one)

☐ Annual

☐ Seasonal/Dates _____

☐ Temporary/Dates/Time _____

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

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 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

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 #:**_____