

Boston Inspectional Services Department  
Division of Health Inspections  
1010 Massachusetts Avenue  
Boston, MA 02118  
(P) 617-635-5326  
(F) 617-635-5388

**PLAN REVIEW PROCEDURES** (for a new establishment without a current permit)

1. Fill out a Health Division Application
2. Pay appropriate fees
3. Have three (3) copies of plans for review
4. Submit one (1) copy of all new equipment specification forms from manufacturer w/NSF/UL approval. NSF standard #7 for refrigeration
5. Submit one (1) copy of menu w/consumer advisory if appropriate

**AFTER HEALTH DIVISION APPROVAL**

1. Submit stamped plans to Building Division w/ Building Permit applications and appropriate fees
2. Building permit has to be signed off by appropriate inspectors
3. Apply/obtain the appropriate Certificate of Occupancy and/or Certificate of Inspection from Building Division
4. Bring copy of CO/CI to Health Division
5. Request a "Pre-Opening" inspection from the Health Division
6. Submit a copy of the Food Manager Certification & Worker's Compensation Insurance to the Health Division
7. GOOD LUCK!!



# 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

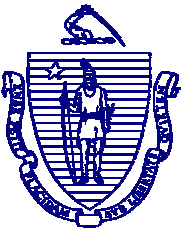
Permit # Issued

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:

<b>14) Source of Water _____</b> <b>Sewage Disposal</b>		<b>15) Rubbish Disposal Co. _____</b> <b>Rendering Co. (For Grease)</b>													
<b>16) Days and Hours of Operation:</b>		<b>17) No. of Food Employees</b>													
<b>18) Name of Person In Charge Certified in Food Protection Management:</b>															
<small>Required as of 10/1/2001 in accordance with 105 CMR 590.003(A). Please attach copy of certificate.</small>															
<b>19) Person Trained In Anti-Choking Procedures (if 25 seats or more):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No															
<b>20) Location:</b> (check one) <input type="checkbox"/> Permanent Structure <input type="checkbox"/> Mobile Reg.#: _____ Base of Operation: _____		<b>21) Establishment Type (check all that apply)</b> <table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> Retail (      sq.ft)</td> <td><input type="checkbox"/> Caterer</td> </tr> <tr> <td><input type="checkbox"/> Food Service (      Seats)</td> <td><input type="checkbox"/> Food Delivery</td> </tr> <tr> <td><input type="checkbox"/> Food Service-Takeout</td> <td><input type="checkbox"/> Residential Kitchen for Retail Sale</td> </tr> <tr> <td><input type="checkbox"/> Food Service-Institution (      Meals/Day)</td> <td><input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home</td> </tr> <tr> <td>(      Beds)</td> <td><input type="checkbox"/> Residential Kitchen for Bed and Breakfast Estab.</td> </tr> <tr> <td><b>Other (Describe):</b></td> <td><input type="checkbox"/> Frozen Dessert Manufacturer</td> </tr> </table> _____ _____		<input type="checkbox"/> Retail (      sq.ft)	<input type="checkbox"/> Caterer	<input type="checkbox"/> Food Service (      Seats)	<input type="checkbox"/> Food Delivery	<input type="checkbox"/> Food Service-Takeout	<input type="checkbox"/> Residential Kitchen for Retail Sale	<input type="checkbox"/> Food Service-Institution (      Meals/Day)	<input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home	(      Beds)	<input type="checkbox"/> Residential Kitchen for Bed and Breakfast Estab.	<b>Other (Describe):</b>	<input type="checkbox"/> Frozen Dessert Manufacturer
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<b>Other (Describe):</b>	<input type="checkbox"/> Frozen Dessert Manufacturer														
<b>22) Length of Permit:</b> (check one) <input type="checkbox"/> Annual <input type="checkbox"/> Seasonal/Dates  <input type="checkbox"/> _____ Temporary/Dates/Time															
<b>23) Food Operations:</b> (check all that apply):		<b>Definitions:</b> <i>PHF-potentially hazardous food (time/temperatures controls required)</i> <i>Non-PHF's-non-potentially hazardous food (no time/temperature controls required)</i> <i>RTE-ready-to-eat foods (Ex. Sandwiches, salads, muffins which need no further processing)</i>													
<input type="checkbox"/> Commercially Pre-Packaged Non-PHF's		<input type="checkbox"/> PHF Cooked To Order													
<input type="checkbox"/> Commercially Pre-Packaged PHFs		<input type="checkbox"/> Preparation of PHFs For Hot And Cold Holding For Single Meal Service													
<input type="checkbox"/> Preparation of Non-PHF's		<input type="checkbox"/> Sale of Raw Animal Foods Intended to be Prepared by Consumer													
<input type="checkbox"/> Reheats Commercially Processed Food for service within 4 hours		<input type="checkbox"/> Customer Self-Service													
<input type="checkbox"/> Customer Self-Service Of Non-PHF and Non-Perishable Foods Only		<input type="checkbox"/> Ice Manufactured and Packaged for Retail Sale													
<input type="checkbox"/> Delivers Food Within 1 Hour of Preparation		<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale													
<b>Other (Describe):</b> _____ _____		<input type="checkbox"/> Offers RTE PHF in Bulk Quantities													
		<input type="checkbox"/> Retail Sale of Salvage, Out-of Date or Reconditioned Food													
<b>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.</b>															
<b>24) Signature of Applicant:</b> _____															
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.															
<b>25) Federal ID:</b> _____															
<b>26) Signature of Individual or Corporate Name:</b> _____															



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 #: \_\_\_\_\_