

**Town of West Stockbridge
Board of Health**

Application – Food Establishment Permit

Please type or print neatly. All items must be completed, Non-applicable items should be indicated by "N/A". Incomplete applications can not be processed. Copies of all related certificates must be included.

Signing this application certifies that the applicant and the establishment will operate and abide by the provisions of 105 CMR 590.000 State Sanitary Code Article X: Minimum Sanitation Standards for Food Service Establishments.

___ New License

___ Renewal

Name of Establishment _____ Telephone # _____
Business Address _____ Email: _____
Mailing Address (if different) _____
Name and Title of Applicant _____
Name of Owner (if different) _____

Corporations or Partnerships: Give name, title, and home address of officers and partners.

Name

Title

Home Address

State of Incorporation _____

Name of Local Agent _____ Telephone # _____
Address _____
Emergency Contact _____ Telephone # _____
Address _____

Check applicable type of license (a separate application is required for each license type).

Type of Establishment	Permit Fee		Duration of Permit	Amount Due
	<u>Annual</u>	<u>Seasonal*</u>		
___ Retail Food	\$ 50.00		___ Annual	_____
___ Food Service	\$ 50.00	\$ 50.00		_____
___ Caterer	\$ 50.00	\$ 50.00		_____
___ Mobile Vendor**	\$ 25.00	\$ 25.00	___ Seasonal	_____
___ Residential Kitchens	\$ 50.00	\$ 50.00		_____
___ Bed and Breakfast	\$ 50.00			_____
___ Special Event Service	\$ 25.00		___ Temporary	_____
___ Farmers Market ***		\$ 25.00		_____

Dates and Hours of Operation (ALL) _____

Types of Food Served _____

*Seasonal licenses – May 1 to October 31, or any time in between.

**Applications for mobile vendors must include a list of handwash and toilet facilities available on each route.

***No preparation of food on site, provide certification of facility where food is prepared with application

Water Source _____ Sewage Disposal _____

Seating Capacity (Actual)

Restaurant _____

Bar _____

Certified Person-In Charge? Yes No

Person trained in anti-choking procedures (if 25 seats or more)? ☐ Yes ☐ No

Certified Person - Allergen Training? ☐ Yes ☐ No

Date of Application

Signature of Applicant

Pursuant to MGL Ch. 62, sec 49A, I certify, under the pains and penalties of perjury, that I—to the best of my knowledge and belief—have filed all state tax returns and paid all state taxes as required under law.

**Social Security # or
Federal Identification #**

Individual or Corporate Name

by _____
Signature of Individual or Corporate Officer

Mobile Vendors: List of Handwash and Toilet Facilities

- 1 _____
- 2 _____
- 3 _____

Make Check Payable to "Town of West Stockbridge" and return to:

West Stockbridge Board of Health
PO Box 81
West Stockbridge, MA 01266
Tel: 413-232-0300 ext. 314