Town of Ashland

MASSACHUSETTS

Form Revision Date: April, 2018

Application for a Permit to Operate a Food Establishment

Check one: **New** ____________ **Renewal** ____________ **Updating Information** ____________

Today's Date: ______________________________ Date of Event (if one day event) ________________

Establishment Name: ____

Establishment Address: ____

Establishment Telephone: ____

Owner Information

Owner of Establishment: ____

Mailing address if different from above: ____

Owner's Email Address: ____

Telephone Number(s) ________________ (h) ____________________(c) ____________________ (alt)

Emergency Contact Person: ____

Emergency Telephone Number: ____

Emergency Contact Person's Email Address: ____

If this is a Corporation or Partnership, give name, and home address of the officers or partners.

Name **Title** **Address**

____

____

State of incorporation: __________

Type of Establishment:	Fee	Duration of Permit	
Retail Food	_________	Annual	_________
Food Service	_________	Transfer	_________
Caterer	_________	Temporary	_________
Mobile Food*	_________	Seasonal	_________
Total Fee:	_________		

Payment is due with the completed application form.

Please make checks payable to Town of Ashland.

***Applications for mobile food units or pushcarts must include a list of hand wash and toilet facilities available on each route. Attach separate sheet.**

Establishment Name & Address: ____

Permit for the year ____________

Establishment Information

Water Source: __________________ Sewage Disposal: __________________

Days and Hours of operation

Days of the week	Operating Hours	Total Hours of operation per day
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
	Total number of hours per week	

Number of Seats: _________________ Square Footage: _________________
Including all displays, sales areas, storage, and processing area.

Does the establishment have person(s) trained in Anti-choking procedures (if 25 seats or more) Yes_____No_____

If **yes**, list below the name (s) of the trained staff(s) and number of hours they work at this establishment and the total number of hours covered by all anti choke trained staff:

#	Full name of the staff trained in anti-Choking	Number of hours of work per week
1		
2		
Total number of hours covered by all of the staffs trained in anti choking procedure per week. This must be at least equal to the total number of operating hours per week. **Submit copies of the proof for anti-choke training.**		

Establishment Name & Address: ____

Permit for the year ____________

List the Names and details of Certified Food Managers who are registered with Ashland Board of Health.

Minimum Requirement: One person onsite with greatest hours in work or volunteer position.

#	Certified Food Manager's Full Name	Certificate #	Employment / Volunteer status at this establishment Full Time/ Part Time/ Volunteer	indicate the number of hours of work /week
1				
2				
3				
Total number of hours per week covered by all of the CFM's at this establishment				
What percentage of the weekly hours of business is covered by the CFMs at the establishment				

Attach additional sheets for additional listing of Certified Food Managers

If there is a change in a) The name of the emergency contact person, b) The telephone number or email of the emergency contact person, c) The officers or their address. d) The list of Certified Foods Managers e) The Certified Food Manager's work status as full time or part time, or volunteer service. You agree to notify in writing to the Board of Health when such changes take effect.

Pursuant to M.G.L. Ch. 62 C, Sec 49A, I certify under the penalties of perjury that I, to the best knowledge and belief, have filed all State tax returns and paid all State and Local taxes required under law.

Print the full name of the above signing authority: ___________________________________

This form needs to be submitted along with the attached statement from each Certified Food Manger(s) who has been contracted to work or volunteer at this establishment. Any additional CFM who are contracted to work or volunteer shall fill in the statement and submit it to the Ashland Board of Health as and when they are contracted by this food establishment.

Establishment Name & Address: ____

Permit for the year ____________

Town of Ashland

MASSACHUSETTS

Form Revision Date: April, 2018

Certified Food Manager – Statement of Fact

(Submit one copy per CFM make additional copies of this page for additional CFMs if any or to submit any changes in the CFM or CFM's work hours.

I, ________________________________ (full name) am a Certified Food Manager registered with the Ashland Board of Health. My Certificate number is _____________________ and it expires on ___________________. I have been contracted to work or volunteer at _______________________________________ (name of the establishment) located at ____ (address of the establishment) as a full time/part time/volunteer (__________hours / per week) as a Certified Food Manager. I agree to notify the Ashland Board of Health in writing if I am no longer associated with this establishment as a Certified Food Manager or if my total number of hours of work per week at this establishment changes.

Under penalties of perjury, I state that the information listed above is true to my knowledge.

____
Signature

Full Name: ___________________________

Date: _______________________________

Contact phone: _____________________________

Establishment Name & Address: ____

Permit for the year ____________