

*town of*  
**LONGMEADOW, MASSACHUSETTS**

*phone: (413) 565-4140      20 Williams Street      01106*



BEVERLY S. HIRSCHHORN, CHO, MPH  
Health Director

**BOARD OF HEALTH**  
MICHAEL COPPOLA, M.D.  
BARRY IZENSTEIN, M.D.  
ROBERT RAPPAPORT, D.M.D.  
RICHARD STEINGART, M.D.  
MARY P. TOYE, R.N., M.S.

**APPLICATION FOR A TEMPORARY FOOD SERVICE ESTABLISHMENT PERMIT**

Name \_\_\_\_\_

Address \_\_\_\_\_ Tel. No. \_\_\_\_\_

Place \_\_\_\_\_ Date \_\_\_\_\_

Menu \_\_\_\_\_

**Source of Food**

A. Where prepared

\_\_\_\_\_

B. By Whom

\_\_\_\_\_

**Food Protection**

A. How will hot foods be maintained at safe temp? (150 or above)

En route \_\_\_\_\_

At site \_\_\_\_\_

B. How will cold foods (perishable) be maintained at safe temps?

En route \_\_\_\_\_

At site \_\_\_\_\_

C. Type structure for food service and preparation

Tent \_\_\_\_\_ Mobile Unit \_\_\_\_\_ Enclosed area \_\_\_\_\_ Other \_\_\_\_\_

THE ABOVE INFORMATION IS REQUIRED TO BE SUBMITTED, IN ACCORDANCE WITH REGULATION 20 OF ARTICLE X OF THE STATE SANITARY CODE. THIS PERMIT IS VALID ONLY FOR THE DATE OR DATES SPECIFIED, AND IN NO CASE TO BE VALID FOR OVER FOURTEEN DAYS.

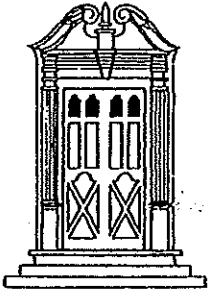
Signature \_\_\_\_\_ Date \_\_\_\_\_

For Businesses Only

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**MANDATORY CERTIFICATION FOR APPLICANTS  
FOR BOARD OF HEALTH LICENSES**

**I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.**

\_\_\_\_\_  
Signature of Individual or Corporate Name  
(Mandatory)

\_\_\_\_\_  
By: Corporate Office Mandatory, if Applicable

\_\_\_\_\_  
Social Security or Federal Identification Number  
(Voluntary)

Your license(s) will not be issued unless this certification clause is signed by the applicant.

Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass G.L.C. 62C. S.49A.



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 600 Washington Street  
 Boston, MA 02111  
 www.mass.gov/dia

For Businesses Only

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

<p><b>Are you an employer? Check the appropriate box:</b></p> <p>1. <input type="checkbox"/> I am a employer with _____ employees (full and/ or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]</p> <p>3. <input type="checkbox"/> 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]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p><b>Business Type (required):</b></p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
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\*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 #: \_\_\_\_\_

<i>Official use only. Do not write in this area, to be completed by city or town official.</i>	
City or Town: <u>LONGMEADOW</u>	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: <u>BEVERLY S. HIRSCHORN</u>	Phone #: <u>(413) 565-4140</u>