



SPRINGFIELD DEPARTMENT OF HEALTH AND HUMAN SERVICES
 DIVISION OF ENVIRONMENTAL HEALTH
 311 STATE STREET
 SPRINGFIELD, MA 01105
 T: (413) 787-6740 FAX: (413) 787-6458

IN ACCORDANCE WITH THE STATUTORY AUTHORIZATION MASSACHUSETTS GENERAL LAW 94, THE UNDERSIGNED HEREBY APPLIES FOR:
 FOOD SERVICE ESTABLISHMENT () RETAIL FOOD ESTABLISHMENT () BAKERY PERMIT () CATERER () MOBILE FOOD/PUSH CART
 () FOOD SERVICE RESIDENTIAL () MILK () FROZEN DESSERT ()

DATE: _____ EMAIL: _____

ESTABLISHMENT NAME: _____ TEL: _____

ADDRESS: _____
 STREET CITY STATE ZIPCODE

MAILING ADDRESS: _____
 STREET CITY STATE ZIPCODE

OWNER NAME: _____

OWNER ADDRESS: _____

IF CORPORATION/PARTNERSHIP, GIVE NAME, TITLE TELEPHONE NUMBER, AND HOME ADDRESS OF OFFICER OR PARTNERS.

| NAME | TITLE | HOME ADDRESS | TELEPHONE |
|------|-------|--------------|-----------|
| | | | |

DAYS/HOURS OF OPERATION: _____

- | | |
|---|--|
| <input type="checkbox"/> FOOD SERVICE ESTABLISHMENT: \$175 | <input type="checkbox"/> FOOD SERVICE <u>RESIDENTIAL</u> \$100 |
| #SEATS _____ | |
| STAFF TRAINED IN ANTI- CHOKING PROCEDURE | |
| (IF # OF SEATS IS 25 OR MORE) | <input type="checkbox"/> BAKERY PERTMIT \$100 |
| YES ___ NO ___ IF YES, NUMBER TRAINED _____ | |
| <input type="checkbox"/> RETAIL FOOD ESTABLISHMENT \$175 | <input type="checkbox"/> MILK \$25 |
| <input type="checkbox"/> CATERER \$125 | WHERE IS MILK OBTAINED: |
| BASE OF OPERATION: _____ | NAME _____ ADDRESS _____ |
| LICENSED FOOD ESTABLISHMENT | |
| <input type="checkbox"/> MOBILE FOOD/PUSH CART | <input type="checkbox"/> FROZEN DESSERT \$40 |
| ATTACH A LIST OF HAND WASH/TOILET FACILITIES AVAILABLE ON EACH ROUTE. | FOR MADE AND SERVED ITALIAN ICES |
| FULL SERVICE MOBILE TRUCK \$250 | AND SOFT SERVE (NOT VENDOR |
| HOT DOG (ONLY) CART \$125 | PACKAGED ICE CREAM, DESSERTS, ETC.) |
| BASE OF OPERATION _____ | |
| LICENSED FOOD SERVICE ESTABLISHMENT | |

PURSUANT OF M.G.L. CHAPTER 62C, SECTION 49A, I CERTIFY UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE RETURNS AND PAID ALL STATE TAXES REQUIRED BY LAW.

 S.S.N. #/ FEDERAL ID #

 CORPORATE NAME/ SIGNATURE OF APPLICANT

NAME OF INDIVIDUAL COMPLETING APPLICATION: _____

ADDRESS: _____

TELEPHONE: _____