CITY OF SPRINGFIELD
LICENSING DEPARTMENT

36 Court Street, Room 305
Springfield, MA 01103
413-787-6140
FAX 413-787-6528

APPLICATION FOR COMMON VICTUALLER (RESTAURANT) LICENSE

$125 New License

Certified Check or Money Order Only
Attach a Copy of Your Current Health Permit

2026

_____New License Request

1. Individual or Corporate Name: _____Tel. No: _____

   a. Individual Social Security No. or Corporate FID no. _____

   b. Individual or Corporate E-MAIL ADDRESS _____

2. Trade Name (d/b/a.): _____

3. Address of Premises: _____ Zip Code_____

4. Detailed Description of Premises (specify the floors to be licensed): _____

   a. Has the premises been altered since the last Common Victualler (Restaurant) License was issued?
   _____ Yes _____ No _____ Not Applicable

   b. If yes, please detail the alteration: _____

5.Does the described premises have a Certificate of Occupancy ("CO") and an annual Certificate of Inspection ("CI")?

   Note: *A "CO" is issued by the Code Enforcement, Building Division 413-787-6031*
   "CI" is issued jointly by the Code Enforcement, Building Division and the Fire Department 413-787-6411 and is applicable to restaurants that seat fifty [50] or more people and all restaurants with liquor licenses.

   a. CO: _____ Yes _____ No

   b. CI: _____ Yes, _____ No _____ Not Applicable (premises seats less than 50)

6. Does Licensee have all necessary licenses from the Health & Human Services (413) 787-6741) to operate the business? _____ Yes _____ No

Please list which Health & Human Services licenses:

_____ Food Service _____ Mobile
_____ Retail _____ Milk
_____ Caterer _____ Frozen Desserts
_____ Food Service Residential _____ Other

7. What time will you open? M_____ T_____ W _____ Th _____ F_____ Sat_____ Sun_____

What time will you close? M_____ T_____ W _____ Th _____ F_____ Sat_____ Sun_____

8. Landlord:

_____
Name

_____
Home Address Line 1

_____
Address Line 2

_____
Home Telephone

9. Restaurant Manager:

_____
Name

_____
Home Address Line 1

_____
Address Line 2

_____
Home Telephone

_____
Cell Phone

Restaurant Manager's Signature: _____

TAX CERTIFICATION AFFIDAVIT

Individual Social Security Number _____ State Identification Number _____ Federal Identification Number _____

If sole proprietor please provide Driver License Number and DOB:_____

Company: _____ _____

P.O. Box (if any): _____ Street Address Only: _____

City/State/Zip Code: _____

Telephone Number: _____ Fax Number: _____

List address(es) of all other property owned by company in Springfield: _____

State whether the applicant is a:

Corporation _____

Individual _____ Name of Individual: _____

Partnership _____ Names of all Partners: _____

Limited Liability Company _____ Names of all Managers: _____

Limited Liability Partnership _____ Names of Partners: _____

Limited Partnership _____ Names of all General Partners: _____

I UNDERSTAND THAT ANY FALSE STATEMENTS CONTAINED HEREIN MAY RESULT IN THE REJECTION OF THIS APPLICATION, OR THE SUBSEQUENT REVOCATION OF MY CURRENT LICENSE.

FEDERAL TAX CERTIFICATION

I, _____ certify under the pains and penalties of perjury that _____, to my best
(Authorized agent) (Applicant)
knowledge and belief, has/have complied with all **United States Federal taxes** required by law.

_____ _____ Date: _____
Applicant Authorized Person's Signature

CITY OF SPRINGFIELD TAX CERTIFICATION

I, _____ certify under the pains and penalties of perjury that _____, to my best knowledge and
(Applicant agent) (Applicant)

belief, has/have complied with all **City of Springfield taxes** required by law (or has/have entered into a Payment Agreement with the City).

_____ _____ Date: _____
Applicant Authorized Person's Signature

COMMONWEALTH OF MASSACHUSETTS TAX CERTIFICATION

I, _____ certify under the pains and penalties of perjury that _____
(Authorized agent) (Applicant)

to my best knowledge and belief, has/have complied with all **laws of the Commonwealth of Massachusetts** relating to taxes, reporting of employees and contractors, and withholding and remitting child support.

_____ BY: _____ Date: _____
Applicant Authorized Person's Signature

Notary Public

COMMONWEALTH OF MASSACHUSETTS

_____,ss. _____, 202__

Then personally appeared before me [name]_____,[title]_____

of [company name]_____, being duly sworn, and made oath that he/she has read the foregoing document,

and knows the contents thereof; and that the facts stated therein are true of his/her own knowledge, and stated the foregoing to be his/her free

act and deed and the free act and deed of [company name]_____.

_____

Notary Public

My commission expires: _____

NOTE****If the applicant has not held a license in the year prior to this application, applicant must file a duplicate of this application with the registrar. (See MGL 140 § 59).**

YOU MUST FILL THIS FORM OUT COMPLETELY AND YOU MUST FILE THIS FORM WITH YOUR Application.

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

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 #: