

THE FOLLOWING IS REQUIRED BEFORE THE APPLICATION AND FEE WILL BE ACCEPTED. NO EXCEPTIONS.

- Copies of well water analysis**
- Copies of all certificates of employees certified in Servsafe, Allergy Awareness, and Choke Saver Training**
- Certificate of Worker's Compensation Insurance (see attached)**
- Certificate of Liability Insurance**

FOR SEASONAL FOOD ESTABLISHMENTS, OPENING INSPECTIONS MUST BE SCHEDULED AND CONDUCTED NO LATER THAN 2 WEEKS PRIOR TO PLANNED OPENING DATE.



**TOWN OF EASTHAM
BOARD OF HEALTH**
2500 State Highway, Eastham, MA 02642
508-240-5900
Fax 508-240-5908
Email: health@eastham-ma.gov

FOR BOARD OF HEALTH USE ONLY

Date Rec'd: _____ \$
 Payment Type: _____ Allergen Awareness
 Servsafe Cert. Chokesaver Cert.
 Well water analysis Certificate of Worker's Comp
 Certificate of Liability Insurance
 Reviewed By: _____
 OK Hold _____

FE# _____
 TOB# _____
 MILK# _____
 ICE# _____

FOOD ESTABLISHMENT PERMIT APPLICATION

Renewal	*New _____ *New businesses must meet with the Health Agent and file application at least 30 days prior to opening.		
1)	Establishment Name:		
2)	Establishment Address:		
3)	Establishment Mailing Address (if different):		
4)	Establishment Phone #:	Email Address:	
5)	Applicant Name:		
6)	Applicant Address:		
7)	Applicant Mailing Address (if different):		
8)	Applicant Phone #:	Email Address:	
9)	Business Owned By:	10) If a Corporation or partnership, give name, title, and address of officers or partner:	
	<input type="checkbox"/> An Association <input type="checkbox"/> A Corporation <input type="checkbox"/> An Individual <input type="checkbox"/> A Partnership <input type="checkbox"/> Other Legal Entity _____	<u>Name</u> <u>Title</u> <u>Mailing Address</u> <hr/> <hr/>	
11)	Person Directly Responsible for Daily Operations (ex. Owner, PIC, Supervisor, Manager, etc.):		
	Name & Title:		
	Address:		
	Phone #:	24 Hour Emergency #:	
	Email Address:		
12)	Water Source: DEP Public Water Supply #:		
13)	Sewage Disposal:		
14)	Days and Hours of Operation:		
15)	# of Food Employees:		

16)	Servsafe Certified Employees:		
	<u>Name</u>	<u>Certificate #</u>	<u>Expiration Date:</u>
1.			
2.			
3.			
17)	Allergy Awareness Trained Employees:		
	<u>Name</u>	<u>Certificate #</u>	<u>Expiration Date:</u>
1.			
2.			
3.			
18)	Choke Saver Trained Employees (required if 25 seats or more in establishment):		
	<u>Name</u>	<u>Certificate #</u>	<u>Expiration Date:</u>
1.			
2.			
3.			
19)	Location Type:		
20)	Length of Permit:	if Seasonal, dates of operation:	
21)	Establishment Type:		
22)	# of Seats:		
23)	Food Operations:		
24)	Sale of Tobacco Products:		

I, the undersigned, attest to the accuracy of the information provided in this application and further agree to allow the regulatory authority access to the establishment as specified under 8-401.11. I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law.

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

Signature of Applicant: _____ **Date:** _____

Social Security # or Federal ID #: _____