

FOR HEALTH DEPARTMENT USE ONLY

Date Received

Date Inspected

Approved By

Permit # Issued



Town of Carlisle Board of Health Food Establishment Permit Application

(Application must be submitted at least 30 days before the planned opening date, or expiration date of an existing permit)

1) Establishment Name:													
2) Establishment Address:													
3) Established Mailing Address (if different):													
4) Establishment Telephone No.:	Fax No.:												
5) Applicant Name & Title:													
6) Applicant Address:													
7) Applicant Telephone No.:	24 Hour Emergency No.:												
8) Owner Name & Title (if different from applicant):													
9) Owner Address (if different from applicant):													
10) Establishment Owned By: <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 _____	11) If a corporation or partnership, give name, title and home address of officers or partner. <table style="width:100%; border:none;"> <tr> <td style="text-align:center;"><u>Name</u></td> <td style="text-align:center;"><u>Title</u></td> <td style="text-align:center;"><u>Home Address</u></td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td>_____</td> <td>_____</td> <td>_____</td> </tr> </table>	<u>Name</u>	<u>Title</u>	<u>Home Address</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____
<u>Name</u>	<u>Title</u>	<u>Home Address</u>											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
12) Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.)													
Name & Title:	_____												
Address:	_____												
Telephone No.:	Fax:												
Emergency Telephone No.:	_____												
13) District or Regional Supervisor (if applicable)													
Name & Title:	_____												
Address:	_____												
	Fax:												

Food Establishment Information

14) Water Source: DEP Public Water Supply No: (if applicable)		15) Sewage disposal:	
16) Days and Hours of Operation:		17) No. of Food Employees:	
18) Name of Person In Charge Certified in Food Protection Management: <i>Required as of 10/1/2001 in accordance with 105 CMR 590.003(A) Please attach copy of certificate</i>			
19) Person Trained in Anti-Choking Procedures (if 25 seats or more): <input type="checkbox"/> Yes <input type="checkbox"/> No			
20) Location: (check one) <input type="checkbox"/> Permanent Structure <input type="checkbox"/> Mobile *	22) Establishment Type (check all that apply) <input type="checkbox"/> Retail (Sq. Ft.) <input type="checkbox"/> Food Service- (Seats) <input type="checkbox"/> Food Service- Takeout <input type="checkbox"/> Food Service-Institution (Meals/Day) <input type="checkbox"/> Other (Describe)		
21) Length of Permit: (check one) <input type="checkbox"/> Annual <input type="checkbox"/> Seasonal/Dates: <input type="checkbox"/> Temporary Dates/Time:	<input type="checkbox"/> Caterer <input type="checkbox"/> Food Delivery <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Establishments <input type="checkbox"/> Frozen Dessert Manufacturer		
23) Food Operations: (check all that apply):		Definitions: PHF- potentially hazardous food (time/temperature controls required) Non-PHF-non-potentially hazardous food (no time/temperature controls required) RTE-ready-to-eat foods (Ex. Sandwiches, salads, muffins which need no further processing)	
<input type="checkbox"/> Sale of Commercially Pre-Packaged Non-PHF's	<input type="checkbox"/> PHF Cooked To Order	<input type="checkbox"/> Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service.	
<input type="checkbox"/> Sale of Commercially Pre-Packaged PHFs	<input type="checkbox"/> Preparation Of PHFs For Hot And Cold Holding For Single Meal Service.	<input type="checkbox"/> PHF and RTE Foods Prepared For Highly Susceptible Population Facility	
<input type="checkbox"/> Delivery of Packaged PHFs	<input type="checkbox"/> Sale of Raw Animal Foods Intended to be prepared by Consumer	<input type="checkbox"/> Vacuum packaging/Cook Chill	
<input type="checkbox"/> Reheating of Commercially Processed Foods For Service Within 4 Hours.	<input type="checkbox"/> Customer Self-Service	<input type="checkbox"/> Use of Process Requiring A Variance And/Or HACCP Plan (including bare hand contact alternative, time as public health control)	
<input type="checkbox"/> Customer Self-Service Of Non-PHF and Non-Perishable Foods Only.	<input type="checkbox"/> Ice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Offers Raw Or Undercooked Food of Animal Origin.	
<input type="checkbox"/> Preparations of Non-PHF's	<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Prepares Food/Single Meals for Catered Events or Institutional Food Service	
Other (Describe):	<input type="checkbox"/> Offers RTE PHF in Bulk Quantities <input type="checkbox"/> Retail Sale of Salvage, Out-of-Date or Reconditioned Food	To be completed by the Board of Health Total Permit Fee: _____ Payment is due with application	

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the board of health on how to obtain copies of 105 CMR 590.000 and the federal Food Code.

24) Signature of Applicant: _____

Pursuant to MGL Ch. 62C, sec. 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 required under law.

25) Social Security Number or Federal ID: _____

26) Signature of Individual or Corporate Name: _____