



AVON BOARD OF HEALTH
Buckley Center / 65 East Main St. / Avon, MA 02322
508-588-0414

Food Permit No. _____ Milk & Cream; _____ Frozen Food: _____ Date Rec'D: _____ Total Fee: _____

APPLICATION FOR FOOD ESTABLISHMENT PERMIT

Pursuant to the provisions of 105 CMR 590.000 and Federal Food Code
(Application must be submitted at least 30 days before the planned opening date)

1) Establishment

Name: _____

2) Establishment Address: _____

3) Establishment Mailing Address: _____

4) Establishment Telephone Number: _____

5) Applicant Name & Title: _____

6) Applicant Address: _____

7) Applicant Telephone Number: _____

8) Owner Name & Title: _____

9) Owner Address(if different from applicant): _____

10) Establishment Owned By:

An association A corporation an individual A partnership other _____

11) If a corporation or partnership, give name, title, and home address of officers or partners.

Name

Title

Home Address

<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 and Title: _____

Address: _____

Telephone No: _____ Fax: _____ email: _____

Emergency Telephone: _____

13) District or Regional Supervisor(if applicable)

Name & Title: _____

Address: _____

Telephone No.: _____ Fax: _____

FOOD ESTABLISHMENT INFORMATION

- 14) Water Source: _____ DEP Public Water Supply No: _____
- 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: _____
(Required pursuant to 105 CMR 590.003(A) Attach copy of Certificate)
- 19) Person Trained in Anti-choking Procedures (if 25 seats or more): Yes No
- 20) Location: Permanent Structure Mobile
- 21) Length of Permit: Annual Seasonal (dates _____) Temporary (dates _____)

- 22) Establishment Type:**
- Retail (_____ Sq. Ft.) Food Delivery Food Service-(_____ Seats) Food service-Takeout Residential Kitchen for retail sales Residential Kitchen for Bed and Breakfast Home
 - Food Service- Institution (_____ Meals/day) Residential Kitchen for Bed and Breakfast Establishment.
 - Caterer Frozen Dessert Manufacturer Other (Describe) _____

23) Food Operations: (Check all that apply) *Definitions: PHF- potentially hazardous food(time/temperature controls required)*
Non-PHF- non-potentially hazardous food(no time/temp controls required)
RTE-ready to eat foods(Ex. Sandwiches, salads, muffins which need no further processing)

- Sale of Commercially Pre-Packaged Non-PHF's PHF Cooked to Order customer Self-Service Sale of Commercially Pre-Packaged PHF's Preparation of PHF's for Hot and Cold Holding for a single Meal PHF and RTE Foods Prepared for Highly Susceptible Population Facility Delivery Of Packaged PHF's Sale of Raw Animal Foods Intended to be Prepared By Consumer. Vacuum Packaging/Cook Chill Reheating of Commercially Processed Foods For Service Within 4 Hours Customer Self-service Preparation of Non-PHF's
- Use of Process requiring a Variance And/or HACCP Plan Ice Manufactured. And Packaged for Retail Sale
- Customer Self-Service of Non-PHF and Non-perishable Foods Offers raw or Undercooked Foods of Animal Origin
- Juice Manufactured and Packaged for Retail Sale Prepares Food/Single meals for Catered Events of Institutional Food Service Offers RTE PHF in Bulk Quantities Retail Sale of Salvage, Out-of-date or Reconditioned Food Other(Describe): _____

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

I attest to the accuracy of the information provided in the application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all applicable law. I have been instructed by the board of health on how to obtain copies of 105 CMR 590.00 and federal Food Code.

* Signature of Applicant/Officer **Social Security #(voluntary) or Federal Id. Number

* This license will not be issued unless this certification clause is signed by the applicant.
** Your Social Security # will be furnished to the Massachusetts Department of revenue to be determined 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. General Laws, Chapter 62C, Section 49A.

Permits expire June 30th of this calendar year.

Please return this application with application fee of payable to the Town of Avon

FOR BOARD OF HEALTH USE ONLY

Date Rec'd	Date Inspected	Approved By	BOH #	Amt. Paid	Permit# Issued
_____	_____	_____	_____	_____	_____