



TOWN OF HARWICH

BOARD OF HEALTH

732 Main Street, Harwich, MA 02645

508/430-7509 Fax: 508/430-7531

Email: health@town.harwich.ma.us

FOR BOARD OF HEALTH USE ONLY
 Date Rec'd: _____ Amt. _____
 Pymt. Type: _____ Allergen Awareness
 W/C Food Cert Mgr Chokesaver Card(s)
 Reviewed by initials: _____
 Ok Hold _____

Food Establishment, Retail Food & Tobacco Permit Application

Renewal ____ New* ____ **New businesses must meet with Health Director & file application at least 30 days prior to opening.*

1) Business Name: _____

2) Business Location: _____ Email Address: _____

3) Mailing Address: (if different) _____

4) Business Telephone No.: _____ Business Fax No. _____

5) Owner Name & Title: _____

6) Owner Telephone No.: _____

7) 24 Hour Emergency No.: _____

8) Business Owned By: _____ 9) If a corporation or partnership, give name, title, and address of officers or partner:

<input type="checkbox"/> An association	<u>Name</u>	<u>Title</u>	<u>Mail Address</u>
<input type="checkbox"/> A corporation	_____	_____	_____
<input type="checkbox"/> An individual	_____	_____	_____
<input type="checkbox"/> A partnership	_____	_____	_____
<input type="checkbox"/> Other legal entity _____	_____	_____	_____

10) Person Directly Responsible For Daily Operations: (Owner, Person in Charge, Supervisor, Manager, etc.)
 Name & Title: _____
 Address: _____
 Telephone No.: _____ Emergency No.: _____ Fax: _____

11) **District or Regional Supervisor:** (If applicable)
 Name & Title: _____
 Address: _____ Telephone No.: _____ Fax: _____

12) **Days and Hours of Operation:** _____ No. of Food Employees: _____
 Length of Permit (check one): Annual Seasonal/Dates: _____

13) **List Name of Certified Food Protection Manager And List Name for Allergen Awareness Certification**
Attach Copy of Certificates (At least 1 full-time equivalent **PER SHIFT** required)

_____ Certified Food Protection Mgr. _____ Allergen Awareness Certification
MANDATORY TO RECEIVE FOOD SERVICE PERMIT

14) List Name(s) of Person(s) Trained in Anti-Choking Procedures And Attach Copy of Card(s):

(Required if 25 seats or more) - NO permit shall be issued without copies of valid choke-saver certifications

1. _____ 2. _____

TOTAL # OF SEATS IN ESTABLISHMENT: _____

15) Establishment Type – Fee Schedule: (check all that apply)

Retail: prepackaged food for off-premises consumption

- <50 sq. feet (non PHF only) \$ 50.00
- <600 sq. feet (not primary business) \$ 75.00
- Less than 5,000 sq. feet \$100.00
- 5,000 to 25,000 sq. feet \$150.00
- Greater than 25,000 sq. feet \$250.00

Food Service:

- Caterer \$100.00
- Corollary Facilities \$100.00
- Frozen Dessert \$ 50.00
- Institution \$ 50.00
- Milk & Cream \$ 10.00
- Mobile Food Truck/Cart \$100.00

Food Service: food prepared for individual portion service

- 1 – 30 seats \$100.00
- 31 – 60 seats \$125.00
- 61 – 150 seats \$150.00
- >150 seats \$250.00
- Take out \$ 75.00
- Limited Food Service \$ 50.00

Tobacco:

- Tobacco \$ 50.00

16) Review of Operations: (check all that apply)

<input type="checkbox"/> Sale of Commercially Pre-Packaged Non-Potentially Hazardous Foods	<input type="checkbox"/> Sale of Commercially Pre-Packaged Potentially Hazardous Foods	<input type="checkbox"/> Offers Raw or Undercooked Food Of Animal Origin
<input type="checkbox"/> Preparation of Potentially Hazardous Foods	<input type="checkbox"/> Preparation of Non-Potentially Hazardous Foods, as sole business	<input type="checkbox"/> Potentially Hazardous and Ready-To-Eat Foods Prepared For Highly Susceptible Population Facility
<input type="checkbox"/> Delivery of Potentially Hazardous Foods	<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Customer Self-Service (Describe – ex. salad bar, coffee service, soups):
<input type="checkbox"/> Retail Sale of Salvage, Out-of-Date or Reconditioned Food	<input type="checkbox"/> Prepares Food/Single Meals for Catered Events or Institutional Food Service	_____ _____

If any changes have occurred since our last review, please describe: _____

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 § 8-402.11. I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law.

Pursuant to MGL Ch. 62C § 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 by law.

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

Social Security Number or Federal ID: _____



**The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 1 Congress Street, Suite 100
 Boston, MA 02114-2017
 www.mass.gov/dia**

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

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 #: _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an *employee* is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An *employer* is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

www.mass.gov/dia