



TOWN OF TOPSFIELD - BOARD OF HEALTH
8 West Common Street
Topsfield, MA 01983
(978) 887-1520 phone ~ (978) 887-1521 fax

FOOD ESTABLISHMENT PERMIT APPLICATION
(Application due 30 days before the planned opening date)

Check All That Apply:

- | | |
|--|-------|
| <input type="checkbox"/> Annual | \$75 |
| <input type="checkbox"/> Restaurant | \$125 |
| <input type="checkbox"/> Retail | \$75 |
| <input type="checkbox"/> Limited Retail | \$25 |
| <input type="checkbox"/> Mobile | \$75 |
| <input type="checkbox"/> Caterer | \$25 |
| <input type="checkbox"/> Catered Event | \$20 |
| <input type="checkbox"/> Childcare Facility | \$25 |
| <input type="checkbox"/> Residential Kitchen | \$50 |

Please make checks
payable to the
Town of Topsfield

1. Establishment Name: _____
2. Establishment Address: _____
3. Establishment Mailing Address (if different): _____
4. Establishment Telephone #: _____ Fax #: _____
5. Email: _____
6. Name & Title: _____
7. Applicant Address: _____
8. Applicant Telephone #: _____ 24 Hour Emergency #: _____
9. Establishment Owned By:
☐ An Association ☐ A Corporation ☐ An Individual ☐ A Partnership ☐ Other Legal Entity
10. Owner Name & Title (if different from applicant): _____
11. Owner Address (if different from applicant): _____
12. If a corporation or partnership, give name, title, and home address of officers or partner:
 - o Name & Title: _____
 - o Home Address: _____
 - o Name & Title: _____
 - o Home Address: _____
 - o Name & Title: _____
 - o Home Address: _____
13. Person Directly Responsible for Daily Operations (Owner, Person in Charge, Spvr, Mgr, etc.):
 - o Name & Title: _____
 - o Address: _____
 - o Telephone #: _____ Fax #: _____
 - o Emergency Telephone #: _____ Email: _____
14. District or Regional Supervisor (if applicable):
 - o Name & Title: _____
 - o Address: _____
 - o Telephone #: _____ Fax #: _____
15. Days and Hours of Operation: _____
16. Water Source: _____ DEP Public Water Supply # (if applicable): _____
17. Sewage Disposal: _____
18. No. of Food Employees: _____
19. Certified in Food Protection Management
(Required as of 10/1/2001 in accordance with 105 CMR 590.003(A) Please attach copy of certificate):

Food Establishment Permit Application

20. Person Trained in Anti-Choking Procedures (if 25 seats or more): ☐ Yes ☐ No21. Person Trained in Allergen Awareness – please attach copy of certificate (www.mass.gov/dph/fpp):22. Location: ☐ Permanent Structure ☐ Mobile

23. Food Operations (Check all that apply):

Definitions: **PHF** - Potentially hazardous food (time/temperature controls required)**Non-PHF's** - 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 PHF's	<input type="checkbox"/> Preparation of PHF's 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 PHF's	<input type="checkbox"/> Vacuum Packaging/Cook Chill	<input type="checkbox"/> Sale of Raw Animal Foods Intended to be Prepared by Consumer
<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 a 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"/> Preparation 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 Svc
<input type="checkbox"/> Offers RTE PHF in Bulk Quantities	<input type="checkbox"/> Retail Sale of Salvage, Out-of-Date or Reconditioned Food	
<input type="checkbox"/> Other (Describe):		

24. Establishment Type (check all that apply)

<input type="checkbox"/> Retail (____ Sq. Ft.)	<input type="checkbox"/> Caterer
<input type="checkbox"/> Food Service (____ Seats)	<input type="checkbox"/> Food Delivery
<input type="checkbox"/> Food Service – Takeout	<input type="checkbox"/> Frozen Dessert Manufacturer
<input type="checkbox"/> Food Service Institution (____ Meals/Day)	
Other (describe)	

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.

25. 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.

26. Social Security Number or Federal ID: _____

27. Signature of Individual or Corporate Name: _____



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 Information

Please Print Legibly

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am an 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 #: _____