Rajit Gupta, MPH, RS, CP-FS
Director of Public Health

Board of Health
Town Hall
101 Main Street
Ashland, MA 01721
Phone: 508-881-0100
Fax: 508-881-0182
www.ashlandmass.com

Application for a Permit to Operate a Food Establishment

Check one: **New** _____ **Renewal** _____ **Updating Information** _____

Today's Date: _____

Establishment Name: _____

Establishment Address: _____

Establishment Telephone: _____

Owner Information (NOTE: Any Change of Ownership requires new permit filing)

Owner(s) of Establishment: _____

If you own other Food Establishments in Massachusetts, please list Town(s)_____

Mailing Address if Different from Above: _____

Owner's Email Address(es): _____

Telephone Numbers (C) _____ (H) _____(ALT) _____

Emergency Contact Person / Phone: _____

Emergency Contact Person's Email Address: _____

If this is a Corporation or Partnership, give name, and home address of the officers or partners.

Name **Title** **Address**

_____

State of Corp._____

Type of Establishment:	Fee	Duration of Permit	
Retail Food	_____	Annual	_____
Food Service	_____	Transfer	_____
Caterer	_____	Temporary	_____
Variance	_____	**Total Fee:**	_____

Payment is due with the completed application form.

Please make checks payable to Town of Ashland.

Establishment Information

Water Source: _____ Sewage Disposal: _____

Days and Hours of operation

Days of the week	Operating Hours	Total Hours of operation per day
Monday		
Tuesday		
Wednesday		
Thursday		
Friday		
Saturday		
Sunday		
Total number of hours per week		

Meals to be Served (Check all that Apply): Breakfast ( ) Lunch ( ) Dinner (

Number of Seats: _____ **Square Footage: _____**
Including all displays, sales areas, storage, and processing area.

Does the establishment have person(s) trained in Anti-choking procedures (if 25 seats or more)

Yes _____ **No** _____

If yes, list below the name (s) of the trained staff(s) and number of hours they work at this establishment and the total number of hours covered by all anti choke trained staff:

#	Full name of the staff trained in anti-Choking	Number of hours of work per week
1		
2		
3		
4		
5		
Total number of hours covered by all of the staff members trained in anti-choking procedure per week. This must be at least equal to the total number of operating hours per week. **Submit copies of the proof for anti-choke training.**		

List the Names and details of Certified Food Managers who are registered with Ashland Board of Health. Minimum Requirement: One person onsite with greatest hours in work or volunteer position.

#	Certified Food Manager's Full Name	Certificate #	Employment / Volunteer status- Full Time/ Part Time/ Volunteer	Indicate the number of hours of work /week
1				
2				
3				
Total number of hours per week covered by all of the CFM's at this establishment				
What percentage of the weekly hours of business is covered by the CFMs at the establishment				

Attach additional sheets for additional listing of Certified Food Managers

#	Names of Employees Trained in Allergen Awareness:			
1				
2				

If there is a change in:

a) ***The ownership;***
b) ***The name of the emergency contact person;***
c) ***The telephone number or email address of the emergency contact person;***
d) ***The corporate officers or their address;***
e) ***The list of Certified Foods Managers;***
f) ***The Certified Food Manager's work status as full time or part time, or volunteer service:***

****You agree to notify in writing to the Board of Health when such changes take effect.***

Pursuant to M.G.L. Ch. 62 C, Sec 49A, I certify under the penalties of perjury that I, to the best knowledge and belief, have filed all State tax returns and paid all State and Local taxes required under law.

_____

Signature of Individual or Corporate Officer

Certified Food Manager – Statement of Fact

(Submit one copy per CFM make additional copies of this page for additional CFMs if any or to submit any changes in the CFM or CFM's work hours.

I, _____ (full name) am a Certified Food Manager registered with the Ashland Board of Health. My Certificate number is _____ and it expires on _____. I have been contracted to work or volunteer at _____ (name of establishment where you are currently employed) located at _____ (address of the establishment) as a full time/part time/volunteer (_____hours / per week) Certified Food Manager.

I do/do not work at other food establishments owned by the same owner, for _____ hours per week.

Further, I do/do not work at other (not owned by this owner) food establishments for _____ hours per week.

I agree to notify the Ashland Board of Health in writing if I am no longer associated with any of the listed establishments as a Certified Food Manager or if my total number of hours of work per week changes.

Under penalties of perjury, I state that the information listed above is true to my knowledge.

_____
Signature

Full Name: _____

Date: _____

Contact phone: _____

FOOD EMERGENCY PROTOCOL AGREEMENT

In the event of an emergency or disaster at your food service establishment, you must contact the Ashland Board of Health immediately. We will instruct you on the actions to be taken to resolve the situation.

The following conditions require notification to the following phone number: (508) 881-0100, extension 7922 or 7128, if not immediately available, then please contact the Ashland Fire Department at (508) 881-2323.

- LOSS OF ELECTRICITY OR GAS
- FIRE OR FLOOD
- ONSET OF APPARENT FOODBORNE ILLNESS OUTBREAK
- RAW SEWAGE BACKUP
- INADEQUATE WATER SUPPLY
- INADEQUATE HOT WATER SUPPLY
- UNAPPROVED WATER SUPPLY SOURCE
- CONTAMINATED WATER SUPPLY
- UNAPPROVED FOOD HANDLING PROCESS
- FOOD CONTAMINATION
- STRUCTURAL DEFECTS
- VERMIN INFESTATION
- UNSANITARY CONDITIONS OR OTHER CONDITIONS THAT ENDANGER PUBLIC HEALTH

IF ANY OF THESE OCCUR, STOP AND CALL 508-881-0100 extensions 7922 or 7128 IMMEDIATELY!

Additionally, any modification or renovation to your physical facility, installation of new equipment, or change of ownership shall require a 30-day prior notice and plan submission to the Board of Health as well as the Building Department.

Signed:_____Date: _____