



# TOWN OF DUXBURY

BOARD OF HEALTH  
TOWN OFFICES  
878 TREMONT STREET  
DUXBURY, MASSACHUSETTS 02332-4499

Telephone (781) 934-1100  
Facsimile: (781) 934-1118

## DUXBURY APPLICATION FOR PERMIT TO OPERATE A FOOD ESTABLISHMENT

Date: \_\_\_\_\_  
Name of Establishment \_\_\_\_\_ Phone # \_\_\_\_\_  
Business Address \_\_\_\_\_  
Mailing Address (if different) \_\_\_\_\_  
Name and Title of Applicant \_\_\_\_\_  
Name of Owner (if different from applicant) \_\_\_\_\_

If corporation or partnership, give name, title & home address of officers or partners:

NAME	TITLE	HOME ADDRESS
_____	_____	_____
_____	_____	_____

Emergency Response Person: Name \_\_\_\_\_ Phone # \_\_\_\_\_  
State of Corporation \_\_\_\_\_  
Name & Address of Owner's Agent \_\_\_\_\_

DURATION OF PERMIT	TYPE OF ESTABLISHMENT	AMOUNT TO BE PAID
	Less Than 10,000 sf <input type="checkbox"/> (\$162.00) Retail Food	_____
	Greater Than 10,000 sf <input type="checkbox"/> (\$243.00) Retail Food	_____
	Less Than 40 Seats <input type="checkbox"/> (\$162.00) Food Service	_____
	Greater Than 40 Seats <input type="checkbox"/> (\$216.00) Food Service	_____
Annual <input type="checkbox"/>	(\$ 86.00) Caterer <input type="checkbox"/>	_____
Temporary <input type="checkbox"/>	(\$ 16.00) Milk & Cream <input type="checkbox"/>	_____
Seasonal <input type="checkbox"/>	(\$ 59.00) Frozen Dessert <input type="checkbox"/>	_____
	(\$ 86.00) Bakery <input type="checkbox"/>	_____
	(\$119.00) Sale of Tobacco <input type="checkbox"/>	_____
	(\$ 59.00) Mobile Food <input type="checkbox"/>	_____
	(\$ 22.00) Dumpster <input type="checkbox"/>	_____
	<b>TOTAL:</b>	_____

"The Mission of the Town of Duxbury is to deliver excellent services to the community in the most fiscally responsible and innovative manner while endeavoring to broaden our sense of community and preserve the unique character of our town."

**A \$75.00 FEE WILL BE IMPOSED FOR REINSPECTIONS FOR VIOLATIONS OR COMPLAINTS - TO BE PAID PRIOR TO ISSUANCE OF PERMIT FOR NEXT YEAR.**

NUMBER OF SEATS: \_\_\_\_\_ SQUARE FOOTAGE OF AREA \_\_\_\_\_

Name of Manager/Supervisor/Head Chef: \_\_\_\_\_

Hours of Operation: \_\_\_\_\_

NUMBER OF EMPLOYEES \_\_\_\_\_ # TRAINED IN HEIMLICH MANEUVER \_\_\_\_\_

Dates of Operation if, not Annual: \_\_\_\_\_

WATER SOURCE (Town) \_\_\_\_\_ (Other) \_\_\_\_\_

SEWAGE (Shared) \_\_\_\_\_ (Individual) \_\_\_\_\_ (Municipal) \_\_\_\_\_

GREASE TRAP (NO) \_\_\_\_\_ (YES) \_\_\_\_\_ SIZE \_\_\_\_\_ (Gallons)

Location \_\_\_\_\_

NAME OF DUMPSTER COMPANY: \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF SEWAGE DISPOSAL COMPANY: \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME OF PEST CONTROL COMPANY: \_\_\_\_\_ PHONE # \_\_\_\_\_

PLEASE LIST NAMES OF EMPLOYEES AND FOOD CERTIFICATION/ALLERGEN AWARENESS COURSES TAKEN BY EACH EMPLOYEE. (copies of Certification must be furnished this office)

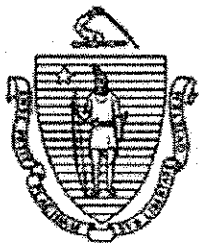
EMPLOYEE

FOOD CERTIFICATION COURSE

\*\*\*\*\*

DO YOU SELL TOBACCO PRODUCTS? \_\_\_\_\_ If yes, I will inform all employees of the laws relating to sale of tobacco to minors. I understand that violation of these laws may result in loss of my Food Establishment Permit. Please describe where in the establishment you will be locating tobacco products for sale.

SIGNATURE \_\_\_\_\_



*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: Builders/Contractors/Electricians/Plumbers**  
**Applicant Information** **Please Print Legibly**

Name (Business/Organization/Individual): \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- |                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>1. <input type="checkbox"/> I am a employer with _____ employees (full and/or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required.]</p> <p>3. <input type="checkbox"/> I am a homeowner doing all work myself. [No workers' comp. insurance required.] †</p> | <p>4. <input type="checkbox"/> I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have employees and have workers' comp. insurance. ‡</p> <p>5. <input type="checkbox"/> We are a corporation and its officers have exercised their right of exemption per MGL c. 152, §1(4), and we have no employees. [No workers' comp. insurance required.]</p> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|

**Type of project (required):**

6. ☐ New construction
7. ☐ Remodeling
8. ☐ Demolition
9. ☐ Building addition
10. ☐ Electrical repairs or additions
11. ☐ Plumbing repairs or additions
12. ☐ Roof repairs
13. ☐ Other \_\_\_\_\_

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

† Homeowners who submit this affidavit indicating they are doing all work and then hire outside contractors must submit a new affidavit indicating such.

‡ Contractors that check this box must attached an additional sheet showing the name of the sub-contractors and state whether or not those entities have employees. If the sub-contractors have employees, they must provide their workers' comp. policy number.

*I am an employer that is providing workers' compensation insurance for my employees. Below is the policy and job site information.*

Insurance Company Name: \_\_\_\_\_

Policy # or Self-ins. Lic. #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Job Site Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**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. Electrical Inspector 5. Plumbing Inspector  
6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

**MASSACHUSETTS DEPARTMENT OF REVENUE**

**REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION**

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

\_\_\_\_\_  
**\*Signature of Individual or Corporate**

\_\_\_\_\_  
**SS# or Federal I. D. Number**

\_\_\_\_\_  
**By: Corporate Officer (Mandatory, if  
Applicable)**

\_\_\_\_\_  
**Date**

- **This license will not be issued unless this certification clause is signed by the applicant.**
- **Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine 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 M.G.L. Chapter 62C, Section 49A.**