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 ($175.00) Retail Food	☐	_____
		Greater Than 10,000 sf ($255.00) Retail Food	☐	_____
		Less Than 40 Seats ($175.00) Food Service	☐	_____
		Greater Than 40 Seats ($230.00) Food Service	☐	_____
Annual	☐	**($ 95.00) Caterer**	☐	_____
Temporary	☐	**($ 25.00) Milk & Cream**	☐	_____
Seasonal	☐	**($ 65.00) Frozen Dessert**	☐	_____
		($ 95.00) Bakery	☐	_____
		($125.00) Sale of Tobacco	☐	_____
		($65.00) Mobile Food	☐	_____
		($30.00) Dumpster	■	_____
			TOTAL:	_____

"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 _____

EMAIL _____

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:

1. ☐ I am a employer with _____ employees (full and/or part-time).*
2. ☐ I am a sole proprietor or partner-ship and have no employees working for me in any capacity. [No workers' comp. insurance required.]
3. ☐ I am a homeowner doing all work myself. [No workers' comp. insurance required.] †
4. ☐ 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.‡
5. ☐ 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.]

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.**