



## Board of Health

459 Main Street, Medfield, MA 02052  
Office (508) 906-3006 ~ fax (508) 359-6182

### FOOD ESTABLISHMENT PERMIT APPLICATION

Name of Establishment: \_\_\_\_\_

Establishment address: \_\_\_\_\_

Establishment phone number: \_\_\_\_\_

Name of Owner: \_\_\_\_\_

Owner's mailing address: \_\_\_\_\_

Owner's phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Name of Applicant: \_\_\_\_\_

Applicant's mailing address: \_\_\_\_\_

Applicant's phone number: \_\_\_\_\_ Email: \_\_\_\_\_

Title/Relationship to establishment (i.e.: owner, manager, et.): \_\_\_\_\_

Establishment owned by: Association Corporation Individual Partnership  
(pls circle) Other legal entity: \_\_\_\_\_

If Corporation or partnership, give name, title and home address of officers or partner:

<u>Title</u>	<u>Name</u>	<u>Address</u>
President:	_____	_____
Vice President	_____	_____
Treasurer	_____	_____
Secretary	_____	_____

Person Directly Responsible for Daily Operations:

Name / Title: \_\_\_\_\_

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

Contact Numbers: \_\_\_\_\_ Email Address: \_\_\_\_\_

District or Regional Supervisor (if applicable):

Name / Title: \_\_\_\_\_

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

Contact Numbers: \_\_\_\_\_ Emergency No: \_\_\_\_\_

Email address for emergency alerts, etc.:

\_\_\_\_\_

\_\_\_\_\_

Trash Removal Company: \_\_\_\_\_

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

Telephone: \_\_\_\_\_

Grease Trap Maintenance Provider:

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

Telephone: \_\_\_\_\_

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Please provide name of staff and confirmation of their safe food handler and allergen certifications

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**Statement:** I hereby certify that the above information is correct, and I fully understand that any deviation from the above without prior permission from the Medfield Board of Health may nullify this approval. I attest that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law.

Applicant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

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.

Signature of Individual or Corporate Name: \_\_\_\_\_

Social Security or Federal ID Number: \_\_\_\_\_

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Approval of these plans and specifications by this Health Department does not indicate compliance with any other code, law or regulations that may be required; federal, state or local. It further does not constitute endorsement or acceptance of the completed establishment (structure or equipment). A pre-opening inspection of the establishment with equipment will be necessary to determine if it complies with the local and state laws governing food service establishments.

**BOARD OF HEALTH USE ONLY**

REVIEWED BY: \_\_\_\_\_

TITLE: \_\_\_\_\_

DATE: \_\_\_\_\_