



Board of Health
459 Main Street
Medfield, MA 02052
(508) 359-8505 x604

MOBILE FOOD ESTABLISHMENT PLAN AND SPECIFICATION REVIEW

Date: _____

*Please **PRINT** all requested information*

This Mobile Food Establishment Plan and specification review is a result of a:

- Check all that apply:
- ☐ New Unit
 - ☐ Remodel project
 - ☐ Conversion project
 - ☐ New operation that is being added
-

Name of Establishment: _____

Establishment address: _____

Establishment phone number: _____

Hours of operation:

Monday	_____	Friday	_____
Tuesday	_____	Saturday	_____
Wednesday	_____	Sunday	_____
Thursday	_____		

Months of operation: _____

Name of Owner: _____

Owner's mailing address: _____

Owner's phone number: _____

Name of Applicant: _____

Applicant's mailing address: _____

Applicant's phone number: _____

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

FOOD ESTABLISHMENT INFORMATION

Name of the approved food source: _____

Location of fixed, licensed food establishment to operate from: _____

Please enclose the following documents:

- ☐ Manufacturer's specification sheets for each piece of equipment (cut sheets).
- ☐ Plan/ Drawing of mobile unit and its components

SPECIFICATIONS

A. Finish Schedule

(Indicate type of material used (i.e.: quarry tile, stainless steel, sealed concrete, terrazzo, ceramic tile, or durable grade plastic)

Please write n/a if not applicable

Food Storage	
Garbage/ Refuse Storage	
Cold Storage Units	
Hot Storage Units	
Cooking Units	

B. Washing/ Sanitizing

1. What type of sanitizer is used?

- ☐ Chlorine/ Bleach
- ☐ Quaternary ammonium compound (QAC)
- ☐ Iodine

Are the appropriate test strips on-hand?

- ☐ Yes
☐ No

2. Please describe the warewashing process including the sanitizing steps of *wash, rinse, sanitize, and air dry*. (All cooking utensils and equipment need to be washed and sanitized)

Where? _____

When? _____

How? _____

C. Garbage and Refuse Outside

1. Is there garbage storage on mobile unit?

- ☐ Yes, if so where: _____
☐ No

2. Where will the garbage be disposed of?

3. Will a dumpster be used?

- ☐ Yes
Number: _____
Frequency of pick-up _____
Contractor: _____
☐ No

4. Describe the surface on which the dumpster/ cans/ containers are to be stored?

Please note: All outside refuse storage containers must be in an enclosed area and stored on or above a smooth surface that is made of a nonabsorbent material that is in good repair.

Description: _____

D. Water Supply

1. Type of water supply:

- ☐ Public
☐ Private

If private, has source been approved?

- ☐ Yes: please attach copy of written approval
 - ☐ No
 - ☐ Pending
-

E. Equipment

1. Are single-service articles for use by the customers provided?
 - ☐ Yes
 - ☐ No
 - ☐ Not applicable
 2. How are condiments, cream, sugar, etc. served?
 - ☐ Sanitary dispensers
 - ☐ Individually wrapped servings
 - ☐ Other: _____
 - ☐ Not applicable
-

F. Handwashing

1. Is there a hand washing sink installed in the unit?
 - ☐ Yes (if so see question 2 below)
 - ☐ No (therefore, limited to the sale of non-potentially hazardous foods and pre-packaged food prepared by a licensed food establishment)
 2. Does the hand washing sink have...?
 - ☐ Hot and cold water
 - ☐ Drying facilities (paper towel)
 - ☐ Soap dispensers (mounted or individual pump dispensers)
-

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.

Applicant's signature: _____

Applicant's printed name: _____

Date: _____

Approval of these plans and specification 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:	_____