

FOR BOARD OF HEALTH USE ONLY

Date Received _____	Permit Fee <u> \$25 </u>	Approved By _____	Permit # Issued _____
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Farmer's Market Permit Application

(Application must be submitted at least 7 business days before the planned opening date)

1) Establishment Name:	
2) Establishment Mailing Address:	
3) Establishment Telephone No:	
4) Applicant/Owner Name & Title:	
5) Applicant/Owner Address:	
6) Applicant/Owner Telephone No:	
7) Applicant/Owner Email address:	
8) Person Directly Responsible For Onsite Operations:	
Name & Title:	
Address:	
Telephone No:	Fax:
Emergency Telephone No:	
9) Check one <input type="checkbox"/> Retail food <input type="checkbox"/> Food Truck <input type="checkbox"/> Caterer <input type="checkbox"/> Other: _____	If preparing food: 10) Water Source: 11) Sewage disposal plan:
12) Please give a brief description of the food to be sold or served:	
13) If samples are being served, please describe sampling protocols:	
14) Food will be prepared: <input type="checkbox"/> Onsite for immediate consumption <input type="checkbox"/> Onsite and held at proper hot/ cold holding temperatures <input type="checkbox"/> Offsite and held at proper hot/ cold holding temperatures <input type="checkbox"/> Offsite, cooled and reheated on site <input type="checkbox"/> Other: _____	15) Solid waste disposal plan:
If PHF is being prepared, please complete food protection questionnaire	

16) If PHF is being served, please list the person who has completed the following trainings and attach appropriate certificates:

- Food Safety Manager: _____
- Allergen Awareness: _____

17) For caterers: City/Town where food establishment permit is held. Please attach a copy of the caterer's permit:

For food trucks, please list additional communities where a food permit is held and attach copies of the permits:

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the board of health on how to obtain copies of 105 CMR 590.000 and the federal Food Code.

18) Signature of Applicant: _____

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.

19) Social Security Number or Federal ID: _____

20) Signature of Individual or Corporate Name: _____

Food Protection Questionnaire for Farmer's Market

Dates at Market: _____

Location of Event: Farmer's Market, 888 South Main Street, Mansfield, MA

List all foods that you will be chilling, holding, cooking, and/or re heating at the event location:

On ice/Refrigerated	Cooking	Reheating
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Food Manager Certification Person Trained On Site? Yes No

Allergen Awareness Menu Label Present? Yes No

List all Potentially Hazardous Food (PHF) and the individual intended temperature required:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List the required temperature for each food as it leaves your preparation site:

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

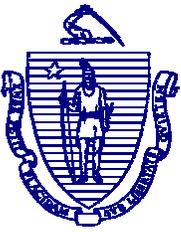
How will the PHF be kept at or below 41°F? _____

How will the PHF be kept at or above 140°F? _____

Time of PHF? Setup _____ Served _____ Removed _____

List all equipment that will be supplied for the Market, including but not limited to food thermometers, cleaning wipes, utensils, non latex gloves, heating utensils, ice etc.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



*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: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: _____

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 partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
- 3. We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
- 4. We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

- 5. Retail
- 6. Restaurant/Bar/Eating Establishment
- 7. Office and/or Sales (incl. real estate, auto, etc.)
- 8. Non-profit
- 9. Entertainment
- 10. Manufacturing
- 11. Health Care
- 12. Other _____

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

**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

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

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. # _____ Expiration Date: _____

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. Licensing Board
- 5. Selectmen's Office
- 6. Other _____

Contact Person: _____ Phone #: _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an **employee** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An **employer** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

www.mass.gov/dia

TAX CERTIFICATION FORM

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 Name

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

***Social Security No. (Voluntary) or Federal
Identification Number*

***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 Massachusetts General Law Chapter 62C, section 49A.