



BOARD OF HEALTH  
**TOWN OF FOXBOROUGH**  
MASSACHUSETTS 02035

www.foxboroughma.gov

40 SOUTH STREET  
Tel. (508) 543-1207  
Fax (508) 543-6278

BHP #: \_\_\_\_\_  
Date Rcvd: \_\_\_\_\_  
Check#: \_\_\_\_\_

## **FOOD ESTABLISHMENT PERMIT APPLICATION**

**(Annual Permit Renewals: Submit by December 1<sup>st</sup>)**

**(New establishments: Submit 30 days prior to opening)**

**(Applications received following the above dates are subject to a \$200 late fee)**

### **Food Establishment Related Information:**

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

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

Establishment Mailing Address (if different): \_\_\_\_\_

Establishment Telephone No.: \_\_\_\_\_

\*Establishment E-mail: \_\_\_\_\_

(\*e-mail to be used for sending electronic inspection reports, permits, and/or other food related information throughout the year).

### **Applicant/Owner Related Information:**

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

Applicant Telephone No.: \_\_\_\_\_

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

\*Licensing E-mail: \_\_\_\_\_

(\*e-mail to be used specifically to send out the annual permit)

Owner's Name (if different from Applicant): \_\_\_\_\_

Owner's Address: \_\_\_\_\_

Owner's Telephone No.: \_\_\_\_\_

24 hour Emergency Contact Name: \_\_\_\_\_

24 hour Emergency Telephone No.: \_\_\_\_\_

**Corporation Related Information:**

Corporate Name: \_\_\_\_\_  
Corporate Address: \_\_\_\_\_  
Corporate Phone Number: \_\_\_\_\_  
Contact Individual: \_\_\_\_\_  
(If Corporate, attach a list of officer names, addresses, and phone numbers)

**Food Establishment Daily Operations - Related Information:**

Name of Person Directly Responsible for the Food Establishment: \_\_\_\_\_  
(i.e. Owner, Person in charge, Manager, etc.)  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_

Name of Immediate Supervisor (Zone, District, Regional): \_\_\_\_\_  
Title: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone No.: \_\_\_\_\_

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

Name of Certified Food Manager (i.e. ServSafe): \_\_\_\_\_  
Expiration Date of Certification: \_\_\_\_\_  
Name of Person Certified in Allergy Awareness: \_\_\_\_\_  
Number of staff trained in Anti-Choking Procedures (if 25 seats or more): \_\_\_\_\_  
(590.009(E): At least one person shall be trained in anti-choke procedures during ALL hours of operation)  
Name of Person(s) trained in Anti-Choking Procedures: \_\_\_\_\_

Fats, Oils, and Grease Information (If using fryolators or have internal/external grease traps)  
Grease Trap Hauler Company: \_\_\_\_\_  
Grease Trap Hauler Telephone No.: \_\_\_\_\_  
Yellow Grease (Fry-o-lator oil) Hauler Company: \_\_\_\_\_  
Yellow Grease Hauler Telephone No.: \_\_\_\_\_

**Foxborough Board of Health Fee Schedule**  
**(Please circle all applicable fees)**

<b><u>Type of Establishment</u></b>	<b><u>Fee</u></b>
Food Service: 1-100 seats	\$50
Food Service: 101-200 seats	\$250
Food Service: 201-500 seats	\$500
Food Service: 501-1000 seats	\$800
Food Service: 1001+ seats	\$1,000
Bakery	\$100
Catering	\$100
Concession Stand	\$350
Limited Food, Limited Retail Food	\$50
Residential Kitchen	\$50
Supermarket	\$800
FOG Permit (if applicable)	\$50

**MAKE CHECK PAYABLE TO "TOWN OF FOXBOROUGH"**  
**CREDIT CARDS ARE NOT ACCEPTED AT THIS TIME**  
**ALL FEES ARE NON-REFUNDABLE AND NON-TRANSFERABLE**

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. **BOTH COPIES MUST BE KEPT ON SITE AT ALL TIMES.\***

Pursuant to MGL Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid state taxes required by law.

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

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

\*Links to both the Federal Food Code and 105 CMR 590.000 can be found under the "Regulations & Helpful Information" section of the Health Department website. Go to [www.foxboroughma.gov](http://www.foxboroughma.gov) to get started.



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.  
 TO BE FILED WITH THE PERMITTING AUTHORITY.

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: \_\_\_\_\_

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

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

<p><b>Are you an employer? Check the appropriate box:</b></p> <p>1. <input type="checkbox"/> I am an 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"/> 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]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p><b>Business Type (required):</b></p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
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\*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 #: \_\_\_\_\_

<i>Official use only. Do not write in this area, to be completed by city or town official.</i>	
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."

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## 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.

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## 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.

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The Department's address, telephone and fax number:

The Commonwealth of Massachusetts  
Department of Industrial Accidents  
1 Congress Street  
Boston, MA 02114-2017  
Tel. # 617-727-4900 ext. 7406 or 1-877-MASSAFE  
Fax # 617-727-7749  
[www.mass.gov/dia](http://www.mass.gov/dia)