



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

www.foxboroughma.gov

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

**APPLICATION TO MAINTAIN AN ESTABLISHMENT FOR  
THE PASTEURIZATION OF MILK LICENSE**

Application must be submitted 30 days before renewal date.  
\$10 Fee – check made payable to Town of Foxborough  
Include \$200 Late Fee if submitted less than 30 days before opening/renewal date.  
*PERMIT EXPIRES ON DECEMBER 31<sup>ST</sup>*

BHP- _____	NO REFUNDS OR TRANSFER OF FUNDS
DATE REC'D _____	
CHECK# _____	

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

Business Name: \_\_\_\_\_

LOCATION OF BUSINESS: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Applicant Phone#: \_\_\_\_\_ Email: \_\_\_\_\_

Make & type of pasteurization apparatus: \_\_\_\_\_

Temperature & time at which milk is to be pasteurized: \_\_\_\_\_

Type of Building Construction: \_\_\_\_\_

Number of rooms for handling and processing milk: \_\_\_\_\_

Estimated quantity of milk to be pasteurized daily: \_\_\_\_\_

Estimated number of employees engaged in the establishment: \_\_\_\_\_

Number of employees who have had Typhoid Fever: \_\_\_\_\_

I have a copy of the regulations:  YES  NO If No, given copy of regulations on \_\_\_\_\_

*This is to certify that this establishment is in compliance with the Regulations of Massachusetts Department of Public Health Relative to Establishments for the Pasteurization of Milk and otherwise in accordance with the provisions of Chapter 259 of the Acts of 1927.*

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_