



Town of West Stockbridge

Board of Health

Application – Food Establishment Permit

Please type or print neatly. All items must be completed, Non-applicable items should be indicated by "N/A". Incomplete applications cannot be processed.

Signing this application certifies that then applicant and the establishment will operate and abide by the provisions of 105 CMR 590.000 State Sanitary Code Article X: Minimum Sanitation Standards for Food Service Establishments.

New License Renewal

Name of Establishment _____ Telephone # _____
Business Address _____
Mailing Address (if different) _____
Name and Title of Applicant _____
Name of Owner (if different) _____

Corporations or Partnerships: Give name, title, and home address of officers and partners.

Name Title Home Address

State of Incorporation _____

Name of Local Agent _____ Telephone # _____
Address _____
Emergency Contact _____ Telephone # _____
Address _____

Check applicable type of license (a separate application is required for each license type).

Type of Establishment	Permit Fee		Duration of Permit	Amount Due
	Annual	Seasonal*		
<input type="checkbox"/> Retail Food	\$ 50.00		<input type="checkbox"/> Annual	_____
<input type="checkbox"/> Food Service	\$ 50.00	\$ 50.00		_____
<input type="checkbox"/> Caterer	\$ 50.00	\$ 50.00		_____
<input type="checkbox"/> Mobile Vendor**	\$ 50.00	\$ 50.00	<input type="checkbox"/> Seasonal	_____
<input type="checkbox"/> Residential Kitchens	\$ 50.00	\$ 50.00		_____
<input type="checkbox"/> Bed and Breakfast	\$ 50.00			_____
<input type="checkbox"/> Special Event Service	\$ 25.00		<input type="checkbox"/> Temporary	_____

Dates and Hours of Operation (ALL) _____

Types of Food Served (temporary permit only) _____

*Seasonal licenses – May 1 to October 31, or any time in between.
**Applications for mobile vendors must include a list of handwash and toilet facilities available on each route.

Water Source _____ Sewage Disposal _____

Seating Capacity (Actual)

Restaurant _____ Bar _____

Person(s)-In Charge (attach copy of certification) _____

Person(s) trained in Allergen Awareness (attach certificate copy) _____

Person trained in anti-choking procedures (if 25 seats or more) _____

I certify, under the pain and penalties of perjury, that the information provided on this application is correct.

Date of Application

Signature of Applicant

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

*Social Security # or
Federal Identification #*

Individual or Corporate Name

by _____
Signature of Individual or Corporate Officer

Mobile Vendors: List of Handwash and Toilet Facilities

Make Check Payable to “Town of West Stockbridge” and return to:

**West Stockbridge Board of Health
PO Box 81
West Stockbridge, MA 01266
Phone: (413) 232-0300 ext. 314**