TOWN OF SAUGUS

BOARD OF HEALTH
298 CENTRAL STREET, SUITE 9
SAUGUS, MASSACHUSETTS 01906

Board of Health
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Director of Public Health

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Public Health
Prevent. Promote. Protect.

APPLICATION FOR PERMIT TO OPERATE A FOOD ESTABLISHMENT

ESTABLISHMENT CONTACT INFORMATION

Name of Establishment: _____ Date: _____

Establishment Address: _____

Name of Owner: _____ Email Address:_____

Manager: _____ Phone No. At Establishment: _____

Emergency Response Person Name: _____ Emergency Phone: _____

If a Corporation or Partnership, attach list of names, titles and home addresses of officers or partners.

State of Name & Address Incorporation_____ of Local Agent _____

TYPE OF ESTABLISHMENT FEE TO BE PAID

Retail Food	Fee: _____	Ice Cream	Fee: _____	Temporary	Fee: _____
Annual	Fee: _____	Caterer	Fee: _____	Seasonal	Fee: _____
Milk	Fee: _____	Frozen Dessert	Fee: _____	No .of Seats	Fee: _____
Food Service	Fee: _____	Mobile Food	Fee: _____	**Tobacco/Nicotine Delivery	
Residential	Fee: _____	Non-Profit	Fee: _____		Fee: _____

Tobacco: A copy of the current Department of Revenue Tobacco License must be attached to this application

TOTAL PERMIT FEE: _____

TIME OF OPERATION

Dates of Operation if not annual: _____

Days and Hours of Operation: _____

RESTAURANT SAFTEY/CERTIFICATION INFORMATION

If Restaurant: Number of Seats: _____ Number of Certified Food Service Managers: _____

Food Safety Manager Certificate Number and Expiration Date: _____

Person Trained in Anti-Choking Procedures (if 25 Seats or more) **Yes:** ☐ **No:** ☐

LAB TESTING: HACCP/APPROVED PROCEDURES INFORMATION

Frozen Desert Testing Lab: _____ (provide last invoice)

Sushi Rice Testing Lab:_____ (provide annual lab test)

PEST CONTROL INFORMATION (*ATTACH LAST INVOICE*)

Name:_____ Telephone Number: _____

Address:_____ Frequency: _____

RUBBISH REMOVAL COMPANY (*ATTACH LAST INVOICE*)

Name:_____ Telephone Number: _____

Address:_____ Frequency: _____

HOOD DUCT CLEANING INFORMATION (*ATTACH LAST INVOICE*)

Name:_____ Telephone Number: _____

Address:_____ Frequency: _____

GREASE TRAP REMOVAL COMPANY (*ATTACH LAST INVOICE*)

Grease Trap Company Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: _____ Internal Grease Trap Size: _____

Frequency Pumped: _____ External Grease Trap Size: _____

Location of External Grease Trap: _____

All pumping records must be forwarded to the Board of Health when grease traps are pumped.

AUTHORIZATION

I have read and understand the Board of Health Regulation, Article 22, Food Service Manager Certification, the Federal Food Code and 105CMR 590.000 State Sanitary Code for Food Establishments as amended October 1, 2000. Copies are available at the State House Bookstore at (617) 727-2834.

***Signature of Applicant:** _____ Date: _____

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

***Signature of Individual or Corporate Name:** _____ Date: _____

FOR BOARD OF HEALTH USE ONLY

Date Received	Check Number	Permit No.	Amount	Taxes and Fees Paid	Late Fee $50.00
_____	_____	_____	_____	☐	☐