



PERMIT APPLICATION FOR TEMPORARY FOOD ESTABLISHMENT

(ANNUAL PERMIT EXPIRES YEARLY ON DECEMBER 31ST UNLESS OTHERWISE NOTED)

THIS APPLICATION MUST BE COMPLETE AND SUBMITTED 14 BUSINESS DAYS PRIOR TO OPERATION.

ANY APPLICATION THAT IS INCOMPLETE, RECEIVED ON, OR POST MARKED LESS THAN 14 BUSINESS DAYS WILL BE ASSESSED AN ADDITIONAL LATE FEE.

***** NO APPLICATION FOR TEMPORARY FOOD ESTABLISHMENTS WILL BE ACCEPTED 3 BUSINESS DAYS OR LESS BEFORE AN EVENT *****



- FULLY COMPLETED APPLICATION PAGES 1 – 8 (**NO BLANK LINES – Put “N/A” if not applicable**)
- COPY OF ALL FOOD LABELS LISTING INGREDIENTS (**Labels are only required for Food(s) that are homemade and/or cottage foods**)
- MASSACHUSETTS REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION (PAGE 5)
- MASSACHUSETTS WORKERS' COMPENSATION INSURANCE AFFIDAVIT (PAGE 6)
- COPIES OF ALL FOOD CERTIFICATIONS & ALLERGEN CERTIFICATIONS REQUIRED BY MENDON'S FOOD CODE REGULATIONS
- COPY OF FOOD ESTABLISHMENT'S MENU
- COPY OF ACORD CERTIFICATE FOR GENERAL LIABILITY INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER
- COPY OF ACORD CERTIFICATE FOR WORKERS' COMPENSATION INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER (*If required on Page 9*)
- NON-REFUNDABLE APPLICATION FEE (CHECKS PAYABLE TO THE TOWN OF MENDON)



**EMAILLED APPLICATIONS
WILL NOT BE ACCEPTED**

ALL APPLICATIONS MISSING PAYMENT, INFORMATION, DOCUMENTATION, AND/OR EXPIRED CERTIFICATION(S) WILL BE DENIED AND RETURNED TO THE APPLICANT, RESULTING IN DELAY OF PROCESSING APPLICATION AND ISSUING OF THE PERMIT.

APPLICATIONS ARE NOT TRANSFERABLE FOR ANY REASON.

**Town of Mendon****Board of Health**

18 Main Street | Mendon, MA 01756

PH: (508) 634-2656 | Email: BOH@MendonMA.Gov

IMPORTANT:Use the **TAB** key to move to the next line – **DO NOT USE** the **ENTER** key.**APPLICATION FOR A TEMPORARY FOOD ESTABLISHMENT PERMIT****NAME OF TEMPORARY FOOD ESTABLISHMENT OPERATION**

TYPE OF TEMPORARY FOOD ESTABLISHMENT	CALENDAR YEAR			
<input type="checkbox"/> TABLE / BOOTH <input type="checkbox"/> TENT <input type="checkbox"/> FOOD CART <input type="checkbox"/> OTHER:	2025	2026	2027	2028
<input type="checkbox"/> 1-DAY EVENT ONLY PERMIT FEE	\$50	\$65	\$70	\$80
<input type="checkbox"/> UP TO 5 EVENTS PERMIT FEE	\$75	\$95	\$110	\$120
<input type="checkbox"/> 6 OR MORE EVENTS (ANNUAL) PERMIT FEE	\$100	\$125	\$145	\$160

ARE YOU A NON-PROFIT ESTABLISHMENT? YES

***NO CHARGE FOR NON-PROFIT ESTABLISHMENTS APPLYING FOR THEIR OWN PERMIT.**
***THIS DOES NOT APPLY TO FOR-PROFIT ORGANIZATIONS PREPARING FOOD FOR A NON-PROFIT EVENT.**

**ANY APPLICATION THAT IS INCOMPLETE, RECEIVED ON, OR POST MARKED
 LESS THAN 14 BUSINESS DAYS WILL BE ASSESSED A LATE FEE TO THE FEE ABOVE**

LATE FEE			
2025	2026	2027	2028
\$50	\$65	\$70	\$80

***** NO APPLICATION FOR A TEMPORARY FOOD ESTABLISHMENT WILL BE ACCEPTED
 3 BUSINESS DAYS OR LESS BEFORE AN EVENT *****

IF YOU ARE A MOBILE FOOD TRUCK/TRAILER – COMPLETE THE MOBILE FOOD ESTABLISHMENT APPLICATION

BOARD OF HEALTH OFFICE USE ONLY	Permit # Issued:	COMPLETED APPLICATION
<input type="checkbox"/> APPLICATION PAGES 1 – 8 COMPLETED (NO BLANK LINES – Put “N/A” if not applicable) <input type="checkbox"/> COPY OF ALL FOOD LABELS LISTING INGREDIENTS <i>(Labels are only required for Food(s) that are homemade and/or cottage foods)</i> <input type="checkbox"/> MASSACHUSETTS REVENUE ENFORCEMENT AND PROTECTION ATTESTATION RECEIVED <input type="checkbox"/> MASSACHUSETTS WORKERS’ COMPENSATION INSURANCE AFFIDAVIT RECEIVED <input type="checkbox"/> COPIES OF ALL FOOD CERTIFICATIONS & ALLERGEN CERTIFICATIONS RECEIVED <input type="checkbox"/> COPY OF FOOD ESTABLISHMENT’S MENU RECEIVED <input type="checkbox"/> COPY OF ACORD CERTIFICATE FOR GENERAL LIABILITY INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER RECEIVED <input type="checkbox"/> COPY OF ACORD CERTIFICATE FOR WORKERS’ COMPENSATION INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER (<i>If required on Page 7</i>) RECEIVED <input type="checkbox"/> NON-REFUNDABLE APPLICATION FEE (CHECKS PAYABLE TO THE TOWN OF MENDON) RECEIVED		
HEALTH AGENT NOTE(S):		

APPROVED **Health Agent Signature:** _____ **Date:** _____

1. ESTABLISHMENT INFORMATION

Establishment Name	Owner/Applicant Name		
Establishment's Physical Address	City/Town	State	Zip Code
Establishment's Mailing Address (<i>If Different from Above</i>)	City/Town	State	Zip Code
Establishment's Phone Number	Email Address: To be used for Communications as in BOH Updates & Reminders of Application(s)		

2. OWNER INFORMATION

OWNING ENTITY IS A(N): Corporation Partnership Association Individual
 Other Entity: _____

Name of Owning Entity	Name of Contact for Owning Entity		
Contact's Address	City/Town	State	Zip Code
Contact's Phone Number	Contact's Email Address		
PERSON DIRECTLY RESPONSIBLE FOR DAILY OPERATIONS	TITLE		
PHONE NUMBER	24-HOUR EMERGENCY PHONE NUMBER		

***** IMPORTANT NOTICE *****

Unless only **NON-TCS Foods** (Time/Temperature Controls Safety, formerly called Potentially Hazardous Food - PHF) are served, each food service establishment shall be required to always have a certified **Food Protection Manager** on staff when food is being prepared and/or served while operating in the Town of Mendon.

3. CERTIFICATIONS (You must provide copies of all current certifications below)

Food Manager Certification is NOT required – This Establishment will NOT be preparing any TCS Foods.

Name(s) of **Certified Food Managers**:

1. _____
3. _____

2. _____
4. _____

Allergen Awareness Training Certificate Holder(s):

1. _____
3. _____

2. _____
4. _____

Anti-Choking Certification Holder(s):

1. _____
3. _____

2. _____
4. _____

4. SIGNATORY SECTION

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 590.00 and all other applicable laws.

I, as the applicant, have read, understand, and will abide by the [Mendon Food Code Regulations](#) that will be in effect as of January 01, 2024.

I, as the applicant, assure agents of the Board of Health access to the licensed/permited facility and applicable records at all reasonable times to inspect the premises for purposes of investigating communicable diseases, investigating into complaints and otherwise protecting public health. Also, as reminder to keep tags and labels with containers of live molluscan shellfish.

I have been instructed by the Board of Health on how to obtain copies of the 105 CMR 590.00 and the Federal Food Code.

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

PRINT NAME

SIGNATURE

DATE

Copies of [105 CMR 590.00](#) and the [Federal Food Code](#) can be obtained at the State House Book Store, Boston, MA (Telephone Number: (617) 727-2834):

**INCOMPLETE APPLICATION SECTION(S) AND/OR EXPIRED CERTIFICATION(S)
WILL BE DENIED AND RETURNED TO THE APPLICANT, RESULTING IN DELAY OF
PROCESSING APPLICATION, SCHEDULING INSPECTION, AND ISSUING OF THE PERMIT.**

APPLICATIONS ARE NOT TRANSFERABLE FOR ANY REASON.

EXPIRATION DATE: DECEMBER 31 OF EACH YEAR, UNLESS OTHERWISE NOTED.

Please make checks payable to:

Town of Mendon

Mail Complete Application and Payment To:

Mendon Board of Health
18 Main Street
Mendon, MA 01756

A. TEMPORARY FOOD ESTABLISHMENT INFORMATION

1. Before completing this application, have you read and understand the [Food Safety at Temporary Events](#) and the [Temporary Food Establishment Operations "Are You Ready?" Checklist](#). YES NO
2. Menu Items: Please check off and list all items below that will be sold. Attach a separate list if more room is needed or submit a full menu, if applicable. **Any changes must be submitted and approved by the Board of Health at least 7 business days prior to the event.**

Check All That Apply: Pre-packaged foods (Chips, Candy, Gum) Pre-packaged Beverages (Soda, Water, Gatorade)
 *Coffee, Tea, Hot Chocolate *Hot Dogs, Hamburgers, Pizza and/or Other TCS foods

***All TCS Foods require Food Manager's Certification, and this person must be on-site when TCS Foods are being prepared or served.**

3. Will all TCS food be prepared at the temporary food service booth?

YES – Fill out **SECTION B: AT THE BOOTH ONLY**

NO – 1. Attach a copy of the food permit and agreement for use of another approved kitchen giving date(s) and times.
2. Fill out both **SECTIONS A and B**

SECTION A: AT THE APPROVED KITCHEN

List each potentially hazardous food item, and for each item, check which preparation procedure will occur.

Food	Thaw	Cut / Assemble	Cook	Cool	Cold Holding	Reheat	Hot Holding	Portion Package
1.								
2.								
3.								
4.								
5.								

SECTION B: AT THE BOOTH

Food	Thaw	Cut / Assemble	Cook	Cool	Cold Holding	Reheat	Hot Holding	Portion Package
1.								
2.								
3.								
4.								
5.								

**NOTE: IF YOUR FOOD PREPARATION PROCEDURES CANNOT FIT THESE CHARTS,
PLEASE LIST ALL OF THE STEPS IN PREPARING EACH MENU ITEM ON AN ATTACHED SHEET.**

B. EVENT UTILITIES

1. Will electricity be provided to Food Unit? YES NO
2. Describe Potable Water Supply: _____
3. Describe means for Wastewater Disposal: _____
4. Describe means for Garbage Collection & Disposal: _____
5. Hand-washing facilities available at booth? YES NO (If no, please explain method of handwashing): _____

HANDWASHING MUST BE AVAILABLE. Handwashing facilities are required, unless **ONLY** pre-packaged foods are being offered. All Temporary Establishments must set up a temporary / portable handwash station (diagram available from BOH) unless there is a handwashing station within 25 feet of the Temporary Establishment's location.

6. Will Gloves be available for use by your employees? YES NO # of Employees: _____ **Disposable gloves & hand sanitizers can provide an additional barrier to contamination but are NOT a substitute for handwashing.**

EVENT UTILITIES CONTINUED

7. Do you have immediate access to a dishwasher or 3-compartment sink? YES NO (If no, please explain method of cleaning utensils and equipment): _____

Utensils must be cleaned or replaced every 4 hours! Separate utensils must be utilized for handling raw and cooked animal foods during the cooking process!!

8. Type of Sanitizer you will be using: _____ (Sanitizer test kit must be available for use at food booth) All food contact surfaces must be sanitized and kept clean at all times.

C. FOOD PROTECTION, TRANSPORTATION & STORAGE

1. Describe measures to protect food and maintain temperature (HOT and COLD) **during transportation** from approved kitchen to event booth:

2. Describe measures to protect food and maintain temperature (HOT and COLD) **while in storage** at event booth:

3. Describe measures to protect food and maintain temperature (HOT and COLD) **during display** at event booth:

FOOD GRADE THERMOMETERS MUST BE ON-SITE TO VERIFY HOT & COLD TEMPERATURES.

4. Water and Ice MUST be from an approved source – list source(s):

ICE USED FOR COLD STORAGE OF FOOD PRODUCTS MUST NOT BE DISPENSED FOR CONSUMPTION TO CONSUMER.

Packaged foods may not be stored in direct contact with ice or water if the food is subject to the entry of water because of the nature of its packaging, wrapping, its container or its positioning in the ice or water – Unpackaged food may not be stored in direct contact with un-drained ice.

5. Explain how food stored in ice will be adequately protected from melting water:

6. How will FROZEN foods be thawed, if necessary, prior to service?

7. Food source(s) – please list all locations at which food will be purchased for this event:

I certify by signing this application that I have read and understand the Massachusetts Department of Public Health “Are You Ready?” checklist for Temporary Food Establishment Operations, and that I am familiar with 105 CMR 590.000 Minimum Standards for Food Establishments and that the described establishment will be operated and maintained in accordance with the regulations.

OPERATOR'S SIGNATURE

DATE

TEMPORARY ESTABLISHMENT EVENT(S) INFORMATION

ESTABLISHMENT NAME

I AM SUBMITTING THE FOLLOWING EVENT(S) FOR THE FIRST TIME

I AM ADDING ADDITIONAL EVENTS TO A PREVIOUSLY APPROVED FOOD PERMIT

Name of Event #1

Date(s) of Event (2 Digit Month and Day for each Date)

Hours of Operation

MENDON, MA 01756

Location of Event

BOH Permit # Issued

Name of Event #2

Date(s) of Event (2 Digit Month and Day for each Date)

Hours of Operation

MENDON, MA 01756

Location of Event

BOH Permit # Issued

Name of Event #3

Date(s) of Event (2 Digit Month and Day for each Date)

Hours of Operation

MENDON, MA 01756

Location of Event

BOH Permit # Issued

Name of Event #4

Date(s) of Event (2 Digit Month and Day for each Date)

Hours of Operation

MENDON, MA 01756

Location of Event

BOH Permit # Issued

Name of Event #5

Date(s) of Event (2 Digit Month and Day for each Date)

Hours of Operation

MENDON, MA 01756

Location of Event

BOH Permit # Issued

TOTAL NUMBER OF CONFIRMED DATES FOR EACH EVENT LISTED: _____

ONLY SUBMIT THIS PAGE IF ADDING MORE EVENTS TO A PREVIOUSLY APPROVED FOOD PERMIT



MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

This request is made under the authority pursuant to Massachusetts General Law Ch. 62C. Section 49A.

I certify under the Penalties of Perjury That I Have Filed All Massachusetts State Tax Returns and Paid ALL Massachusetts State and Town Taxes Required under Law.

Company Name

Company's Physical Address	City	State	Zip
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Company's Mailing Address (If Different from Above)	City	State	Zip
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Company's Phone Number

***Signature of Individual (Mandatory)**

By: Corporate Officer (Mandatory, If Applicable)

****Social Security # (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.



**The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center**

**2 Avenue de Lafayette, Boston, MA 02111-1750
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 and 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 § 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: Board of Health Building Dept. City/Town Clerk Licensing Board

Selectmen's Office 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
Lafayette City Center 2 Avenue de Lafayette,
Boston, MA 02111-1750
Tel. (857) 321-7406 or 1-877-MASSAFE
Fax (617) 727-7749

SAMPLE OF ACORD INSURANCE CERTIFICATE



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:	FAX (A/C, No.):
	PHONE (A/C, No. Ext):	
	E-MAIL:	
	ADDRESS:	
INSURER(S) AFFORDING COVERAGE		NAIC #
INSURED	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES

CERTIFICATE NUMBER:

REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.									
INSR LTR	TYPE OF INSURANCE		ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY							EACH OCCURRENCE	\$
	CLAIMS-MADE <input type="checkbox"/> OCCUR							DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
								MED EXP (Any one person)	\$
								PERSONAL & ADV INJURY	\$
	GEN'L AGGREGATE LIMIT APPLIES PER:							GENERAL AGGREGATE	\$
	POLICY <input type="checkbox"/> PRO- JECT <input type="checkbox"/> LOC							PRODUCTS - COMP/OP AGG	\$
	OTHER:								\$
	AUTOMOBILE LIABILITY							COMBINED SINGLE LIMIT (Ea accident)	\$
	ANY AUTO OWNED AUTOS ONLY <input type="checkbox"/> SCHEDULED AUTOS HIRED AUTOS ONLY <input type="checkbox"/> NON-OWNED AUTOS ONLY							BODILY INJURY (Per person)	\$
								BODILY INJURY (Per accident)	\$
								PROPERTY DAMAGE (Per accident)	\$
	UMBRELLA LIAB			<input type="checkbox"/> OCCUR					\$
	EXCESS LIAB				<input type="checkbox"/> CLAIMS-MADE				
	DED	RETENTION \$						EACH OCCURRENCE	\$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			<input type="checkbox"/> Y/N				AGGREGATE	\$
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)				N / A				
	If yes, describe under DESCRIPTION OF OPERATIONS below							PER STATUTE	OTH- ER
								E.L. EACH ACCIDENT	\$
								E.L. DISEASE - EA EMPLOYEE	\$
								E.L. DISEASE - POLICY LIMIT	\$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101 Additional Remarks Schedule, may be attached if more space is required)

<p>CERTIFICATE HOLDER </p> <p>MENDON BOARD OF HEALTH 18 MAIN STREET MENDON, MA 01756 BOH@MENDONMA.GOV</p>	<p>CANCELLATION</p> <p>SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.</p> <p>AUTHORIZED REPRESENTATIVE</p>
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