PERMIT APPLICATION FOR

PERMANENT FOOD ESTABLISHMENT

THIS APPLICATION MUST BE COMPLETE AND SUBMITTED EACH YEAR PRIOR TO DECEMBER 1ST

ANY APPLICATION THAT IS INCOMPLETE, RECEIVED ON, OR POST MARKED AFTER DECEMBER 1ST WILL BE ASSESSED AN ADDITIONAL LATE FEE.

REVIEW	DOUBLE CHECK	SUBMIT
Review the entire application. Gather all necessary paperwork.	Use the Checklist below to make sure you have everything you need for a complete application.	Submit your application with all required paperwork, insurances, and payment.

ALL BOARD OF HEALTH PERMIT APPLICATIONS SHOULD BE SENT TO ITS MAIN OFFICE

Mendon Board of Health
18 Main Street
Mendon, MA 01756

- ☐ APPLICATION PAGES 1 – 6 ***(For Blank Lines that do not apply to you, please write "N/A")***
- ☐ COPY OF MOST **RECENT SEPTIC DISPOSAL PUMP SLIP** (***If on Private Septic System***)
- ☐ COPY OF MOST **RECENT WATER QUALITY RESULTS** (***For On-Site Wells***)
- ☐ COPY OF MOST **RECENT PEST CONTROL REPORT**
- ☐ COPY OF MOST RECENT **GREASE TRAP MAINTENANCE PUMP SLIP** (***If Applicable***)
- ☐ 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 PAYMENT** OF SELECTED ESTABLISHMENT (CHECKS PAYABLE TO THE TOWN OF MENDON)

EMAILED 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

DUE DATE DECEMBER 1ST FOOD ESTABLISHMENT

IMPORTANT:
Use the **TAB** key to move to the next line – **DO NOT USE** the **ENETER** key.

ANNUAL APPLICATION FOR PERMANENT FOOD ESTABLISHMENT PERMIT

_____
NAME OF FOOD ESTABLISHMENT OPERATION

TYPE OF FOOD ESTABLISHMENT OPERATION – *CHOOSE ONE*	CALENDAR YEAR 2026	2027	2028
☐ Food Service (0-75 Seats) **Fill In # of Seats ➔ ____ Seats Total**	**$125**	**$145**	**$160**
☐ Food Service (76+ Seats) **Fill In # of Seats ➔ ____ Seats Total**	**$250**	**$290**	**$315**
☐ Commercial Kitchen	**$125**	**$145**	**$160**
☐ Retail Food Only	**$125**	**$145**	**$160**
☐ School Kitchen	**NO CHARGE**		
☐ House of Worship	**NO CHARGE**		
☐ ***Non-Profit**	**NO CHARGE**		

No Charge for Non-Profit Organizations 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 AFTER DECEMBER 1ST WILL BE ASSESSED A LATE FEE TO THE FEE ABOVE.

LATE FEE		
2026	2027	2028
$125	$145	$160

BOARD OF HEALTH OFFICE USE ONLY	*Permit # Issued:*	*DATE RECEIVED*

- ☐ APPLICATION PAGES 1 – 6 COMPLETED (NO BLANK LINES)
- ☐ COPY OF MOST RECENT SEPTIC DISPOSAL PUMP SLIP (If on Private Septic System) RECEIVED
- ☐ COPY OF MOST RECENT WATER QUALITY RESULTS (For On-Site Wells) RECEIVED
- ☐ COPY OF MOST RECENT PEST CONTROL REPORT RECEIVED
- ☐ COPY OF MOST RECENT GREASE TRAP MAINTENANCE PUMP SLIP (If Applicable) RECEIVED
- ☐ MASSACHUSETTS REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION (PAGE 5) RECEIVED
- ☐ MASSACHUSETTS WORKERS' COMPENSATION INSURANCE AFFIDAVIT (PAGE 6) RECEIVED
- ☐ COPIES OF ALL FOOD CERTIFICATIONS & ALLERGEN CERTIFICATIONS RECEIVED
- ☐ COPY OF FOOD ESTABLISHMENT'S MENU RECEIVED
- ☐ COPY OF ACORD CERTIFICATE FOR GENERAL LIABILITY INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER RECEIVED
- ☐ COPY OF ACORD CERTIFICATE FOR WORKERS' COMPENSATION INSURANCE WITH THE MENDON BOARD OF HEALTH LISTED AS THE CERTIFICATE HOLDER (If required on Page 7) RECEIVED
- ☐ NON-REFUNDABLE PAYMENT OF SELECTED ESTABLISHMENT (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**

_____ MENDON MA 01756
Establishment's Physical Address **City/Town** **State** **Zip Code**

_____
Establishment's Mailing Address (*If Different from Above*) **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**

3. DAYS AND HOURS OF OPERATION

☐ Operates Year-Round ☐ Operates Seasonally (*If Seasonal – What Month Do You Open?* _____)
What Month Do You Close? _____)

MONDAY: _____ to _____ **SATURDAY:** _____ to _____
TUESDAY: _____ to _____ **SUNDAY:** _____ to _____
WEDNESDAY: _____ to _____
THURSDAY: _____ to _____
FRIDAY: _____ to _____

4. MAINTENANCE (*Leave No Line Blank – Put "N/A" if Not Applicable*)

(Companies marked with ** must be valid and permitted in Mendon) ***See BOH Website for List***

Potable Water Source: ☐ Municipal Water ☐ On-Site Well* (*Please see Page 1*)

******If On-Site Well, please give DEP Public Water Supply Number***: _____

Chemical Sanitizer Used for ***Food Contact Surfaces***: _____

Pest Control Company (***Submit Copy of Most Recent Report***) _____

*****Rubbish Removal Company:*** _____

*****Septic Waste Disposal Company:*** (***Submit Copy of Most Recent Pump Slip***) _____

*****Grease Trap Maintenance Pumping Company:*** _____
(Grease Trap Maintenance Log Must Be Submitted with Application and Presented To Health Agent At Time Of Inspection)

******* 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.

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

☐ **Food Manager Certification is NOT required – This Establishment will NOT be preparing any PHFs.**

Name(s) of **Certified Food Managers**: ***(One must be on site at all times that food is being prepared and/or served.)***

1. _____ 2. _____

3. _____ 4. _____

Allergen Awareness Training Certificate Holder(s):

1. _____ 2. _____

3. _____ 4. _____

Anti-Choking Certification Holder(s): ***(Establishments with 25 seats or more)***

1. _____ 2. _____

3. _____ 4. _____

6. FOOD OPERATIONS (Check All That Apply)

Definitions: **TCS** - Time/Temperature Controls Safety Food (*Formerly called Potentially Hazardous Food - PHF*)

Non-TCS – No Time/Temperature Controls Safety Food (no time/temperature controls required)

RTE – Ready–To-Eat Foods (ex. sandwiches, salad, muffins which need no further processing)

☐ Sale of Commercially Pre-packaged Non-TCS
☐ Sale of Commercially Pre-packaged TCS
☐ Ice Manufactured and Packaged for Retail Sale
☐ Juice Manufactured and Package for Retail Sales
☐ Offers Raw or Under Cooked Food of Animal Origin
☐ Use of Process Requiring a Variance and/or HACCP Plan
☐ Retail Sale of Salvage, Out-of-Date or Reconditioned Food
☐ Reheats commercially processed foods for service within 4 hours
☐ Sale of Raw Animal Foods Intended to be prepared by Consumer
☐ Customer self-service of Non-TCS and Non-Perishable Foods Only
☐ Preparation of TCS for Hot and Cold Holding for Single Meal Service
☐ Prepares Food/Single Meals for Catered Events or Institutional Food Service
☐ Hot TCS Cooked and Cooled or Hot Held for More Than a Single Meal Service
☐ Other (Describe): _____

☐ Preparation of Non-TCS
☐ Delivery of Package TCS
☐ Customer Self-Service
☐ Vacuum Packaging/Cook Chill
☐ Offers RTE TCS in Bulk Quantities

7. 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/permitted 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

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**

_____

Company's Mailing Address (*If Different from Above*) **City** **State** **Zip**

_____

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

Form Revised July 2019

SAMPLE OF ACORD INSURANCE CERTIFICATE

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS 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:	
	PHONE (A/C, No, Ext):	FAX (A/C, No):
	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.

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 ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						☐ PER STATUTE ☐ OTH-ER	
	ANYPROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ Y / N (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						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)

CERTIFICATE HOLDER

MENDON BOARD OF HEALTH
18 MAIN STREET
MENDON, MA 01756
BOH@MENDONMA.GOV

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

ACORD 25 (2016/03) The ACORD name and logo are registered marks of ACORD