



Town of Sudbury

Board of Health

DPW Office Building
275 Old Lancaster Road
Sudbury, MA 01776
978 440-5479

Calendar Year 2019

TO: Sudbury Business Owners

RE: 2019 Food Permit New/Renewal

Food establishments are required by Massachusetts state law to apply, as a new business, or as an annual renewal, for a Food Permit. Permits are valid from January 1, 2019 thru December 31, 2019. Please read through the instructions and fill out the enclosed forms. The Department of health will require the completion of the following forms and applications in order to issue a Food Permit;

- Sudbury Application (enclosed)
- Application Fee (pay to Town of Sudbury – use enclosed Fee Schedule to determine fee amount required to renew)
- Worker's Compensation Insurance Affidavit (enclosed)
- Copy of your Workers Compensation Insurance Declaration page.
- Certifications: ServSafe, Food Allergen, CPR, Choking etc...

If you have any questions or concerns, please do not hesitate to contact us at 978-440-5479.

Thank you for your attention to this matter.

Sincerely,

Bill Murphy
Sudbury Board of Health
health@sudbury.ma.us
Monday-Friday
8:00am-3:00pm
978-440-5479



**SUDBURY HEALTH
DEPARTMENT**

275 OLD LANCASTER ROAD

SUDBURY, MA 01776

Tel (978)440-5479 Fax (978)440-5404

FOR BOARD OF HEALTH USE ONLY

Date Received

Date Inspected

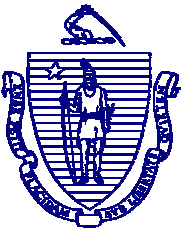
Approved By

Permit # Issued

Fee

2019 Food Establishment Permit Application

1) Establishment Name:	
2) Establishment Address:	
3) Establishment Mailing Address (if different):	
4) Establishment Telephone No:	Email:
5) Applicant Name and Title:	
6) Applicant Address:	
7) Applicant Telephone No:	Email:
8) Owner Name and Title (if different from applicant):	
9) Owner Address (if different from applicant):	
10) Establishment Owned By: <input type="checkbox"/> An association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A Partnership <input type="checkbox"/> Other Legal entity _____	11) If a corporation or partnership, give name, title and home address of officers or partners: <u>Name:</u> <u>Title:</u> <u>Address:</u> _____ _____ _____ _____
12) Person Directly Responsible for Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.)	
Name & Title :	
Address:	
Telephone No:	Email:
Emergency Telephone No:	
13) District Or Regional Supervisor (if applicable)	
Name & Title :	
Address:	
Telephone No:	Email:



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 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 an 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 Section 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 (circle one):

- 1. Board of Health
- 2. Building Department
- 3. City/Town Clerk
- 4. Licensing Board
- 5. Selectmen's Office
- 6. Other _____

Contact Person: _____ Phone #: _____