TOWN OF ANDOVER
MASSACHUSETTS

BOARD OF HEALTH

Health Division
Andover, MA 01810
978-623-8640

APPLICATION FOR PERMIT TO OPERATE A FOOD ESTABLISHMENT

Date:_____

Name of Establishment:_____ Phone:_____

Business Address: _____ E-mail Address: _____

Mailing Address (if different):_____

Name & Title of Applicant:_____

Address of Applicant: _____

Name of Owner (if different from applicant): _____

Owner's address:_____Owner's telephone number: _____

Emergency Response Person: Name:_____ Home Phone:_____

Type of Establishment		Duration of Permit		FEE
****Please Note: Some prices have increased****				
Pushcart	☐	Annual	☐	_____
Retail	☐ $175			_____
Supermarket	☐ $400			_____
Food Service:		Temporary	☐	_____
0-50 seats	☐ $200			_____
51-199 seats	☐ $300			_____
200 + seats	☐ $400	Seasonal	☐	_____
Caterer	☐ $175			_____
Frozen	☐ $ 75			_____
Mobile (Prepackaged)	☐ $100			_____
Mobile (Food Prep)	☐ $175			_____
Res. Kitchen	☐ $150			_____
			TOTAL:	_____

PAYMENT IS DUE WITH APPLICATION

Dates of Operation if not Annual:_____

If Restaurant: Number of Seats:_____ Number of Non-Smoking Seats:_____

Person Trained in Anti-Choking Procedure (if 25 seats or more). Yes:_____ No: _____

*Applications for mobile food units or pushcarts must include a list of the handwash and toilet facilities available on each route. Attach separate sheet.

Additional Information:
Water Source:_____ Sewage Disposal:_____

Days & Hours of Operation:_____ Over

If corporation or partnership, give name, title & home addresses of officers or partners.

Name	Title	Home Address

_____

Signature of Applicant

****THE FOLLOWING SECTION MUST BE FILLED OUT BEFORE PERMIT IS RELEASED.****

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

_____ _____

Social Security Number or Federal Identification Number.

Signature of Individual or Corporate Name

By _____

Corporate Officer (if applicable)

FOR BOARD OF HEALTH USE ONLY

Date	Date Inspected	Approved By	Permit Type	Permit # Issued
_____	_____	_____	_____	_____

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