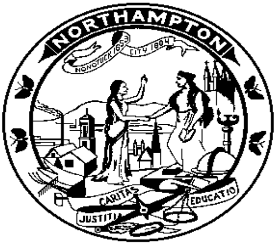

Department of Health & Human Services
Board of Health
212 Main Street
Northampton, MA 01060
Tel: (413) 587-1214
Commissioner: Merridith A. O'Leary, R.S.

FOR BOARD OF HEALTH USE ONLY
Date: ____________________
Amt Received: ______________
Cash/Check No: _____________
Received by: _______________
Workers Comp Affidavit □
DOR Licenses □
Collector's Approval ☐

2026 TOBACCONIST ESTABLISHMENT PERMIT APPLICATION

PERMIT FEE: $250.00 ALL FEES PAID ARE NON-REFUNDABLE FEE

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

Establishment Name: (dba): ______________________________ Establishment Tel.#: __________________

Establishment Address: ____

Mailing Address: ____

Email Address: ____

Applicant Name and Title: ____

Applicant Address: ____________________________________ Applicant Telephone #: ______________

Owner Name & Title (if different from applicant): _____________________________________

Owner Address: ____

A copy of the following MA Department of Revenue License(s) are REQUIRED:

_____ Cigarette Retailer's License Number # ____________________

_____ Cigar and Other Tobacco Product Retail License # ____________________

_____ Electronic Cigarette Retail License # ____________________

_____ Cigarette Distributor's License # ____________________

_____ Electronic Cigarette Distributor's License # ____________________

(A copy of this license(s), or other proof of payment, MUST BE ATTACHED to this Application)

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

Pursuant to MGL Chapter 62C, section 49A, I certify under the penalties of perjury that, to my best knowledge and belief, complied with the law of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.

____ ________________________
Signature of Individual or Corporate Officer Date

____
Telephone #

This permit applies to all tobacco and/or nicotine delivery products.

This form **must** be initialed and signed by the owner of the establishment applying for or renewing a Board of Health Tobacconist Permit.

No permit will be issued until this checklist has been initialed and signed.

_______ **I understand** that no person shall sell tobacco or nicotine delivery products to a minor (21 Years of Age)

_______ **I understand** that this is an Adult Only Store (entry of persons under the age of 21 is prohibited at all times)

_______ **I understand** that the only merchandise that will be for sale is Tobacco and Nicotine Delivery products and paraphernalia

________ **I will** provide the Northampton Department of Health & Human Services with proof of a current **"Cigarette Retail License**" from the Massachusetts Department of Revenue. **(Attach copy of DOR license)**

_______ **I understand** that I am responsible for informing any and all persons who sell tobacco at my business about both state and local regulations pertaining to tobacco sales

_______ **I understand** that the Northampton Board of Health or its designee will conduct frequent compliance checks of my business to ensure that tobacco products are not sold to minors.
This means that:

- The Board of Health will send minors into my establishment who will attempt to purchase tobacco products
- These minors may or may not look 21 years of age
- These minors may or may not have ID

_______ **I understand** that penalties for violation of the regulation include monetary fines and/or suspension of my permit to sell tobacco or nicotine delivery product.

_______ **I understand** Tobacco merchants must have a letter from the manufacturers of each tobacco and vaping product you sell. This requirement applies to all types of tobacco and vaping products. The letter should certify that the tobacco products or vaping products are not flavored. If you are not an "Adult-only Retail Tobacco Store", the letter should also certify that the nicotine content of the vaping products you carry does not exceed 35mg/ml.

_______ **I have read and understand the Regulation of the City of Northampton Board of Health Restricting the Sale of Tobacco Products and Nicotine Delivery Products.**

Signature ____ **Date** ________________________

Please Print Name ____ **Title** _______________________________

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
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 #:____________________________