



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	<input type="checkbox"/>
Food Protection Manager	<input type="checkbox"/>
Allergy Certificate	<input type="checkbox"/>
Base of Operation Permit	<input type="checkbox"/>
Collector's Approval	<input type="checkbox"/>

2026 MOBILE FSE PERMIT APPLICATION

ALL FEES PAID ARE NON-REFUNDABLE

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

AT LEAST 2 weeks of notice is required. Inspection availability is not guaranteed within a 2 week period; therefore, providing as much advance notice is highly recommended.

Establishment Name: (dba): _____ Establishment Tel.#: _____

Establishment Address: _____

Mailing Address: _____

Email Address: _____

License Plate # _____

Applicant Name and Title: _____

Applicant Address: _____ Applicant Telephone #: _____

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

Owner Address: _____

Establishment Owned by (Check one Box) Please attach List of Corporate and Partnership Officers

An Association
 A Corporation
 An Individual
 A Partnership
 Other Legal Entity

If a Corporation or Partnership, give Name, Title, and Home Address of Officers or Partners

Name	Title	Home Address

In Accordance with 105 CMR 590.003 (A) 590.009 and 590.003 (B)

Signature of Corporate Representative (i.e. President, CFO. COO): _____

Signature of Applicant or Corporate Signature: _____

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.

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

FOOD ESTABLISHMENT INFORMATION

Days, and Hours of Operation: _____

Name of Person in Charge Certified in Food Protection Management: _____

Person Trained in Food Allergen Awareness: _____

Base of Operation Name and Location: _____

Method (s) for Hot & Cold Holding of Potentially Hazardous Food Products: _____

PLEASE ATTACH COPIES OF CERTIFICATIONS

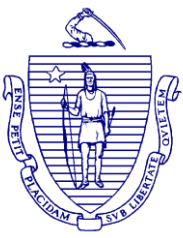
√	Establishment Type	Base Fee	TOTAL
	Mobile FSE	\$150.00	
	Retail Mobile Food Delivery	\$150.00	
		TOTAL	

Water Source: Public Well Sewage Disposal: Public Well

THIS PRODUCT LIST MUST BE COMPLETED PRIOR TO PERMITTING

MOBILE PRODUCT LIST

TYPE OF FOOD PRODUCT MANUFACTURED	LIST OF INGREDIENTS (In order of predominance by weight)	LOCATION AND NAME OF ESTABLISHMENT(S) WHERE SOLD
PRODUCT 1		
PRODUCT 2		
PRODUCT 3		
PRODUCT 4		
PRODUCT 5		
PRODUCT 6		
PRODUCT 7		
PRODUCT 8		
PRODUCT 9		
PRODUCT 10		



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 #: _____