



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"/>
Collector's Approval	<input type="checkbox"/>

## 2026 RESIDENTIAL KITCHEN PERMIT APPLICATION

PERMIT FEE: \$150.00 **ALL FEES PAID ARE NON-REFUNDABLE**

**NO PERMITS WILL BE ISSUED IF TAXES ARE OWED**

*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**

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: \_\_\_\_\_

Establishment Owned by (Check one Box)		Please attach List of Corporate and Partnership Officers			
<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	
If a Corporation or Partnership, give Name, Title, and Home Address of Officers or Partners					
Name	Title	Home Address			
_____					

### 24 Hour Emergency Contact-Person In Charge

Name & Title:	_____
Address:	_____
Telephone #:	_____
24 Hour Emergency #:	_____

Signature of Applicant: \_\_\_\_\_

Signature of corporate Representative (i.e. President, CFO, COO): \_\_\_\_\_

## RESIDENTIAL KITCHEN INFORMATION

Name of Person in Charge Certified in Food Protection Management: \_\_\_\_\_

Person Trained in Food Allergen Awareness: \_\_\_\_\_

Person Trained in Anti-Choking Procedures (if 25 or more seats): \_\_\_\_\_

**PLEASE ATTACH COPIES OF CERTIFICATIONS**

Water Source: <input type="checkbox"/> Public <input type="checkbox"/> Well	Sewage Disposal: <input type="checkbox"/> Public <input type="checkbox"/> Well
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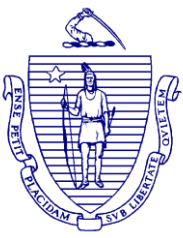
### THIS PRODUCT LIST MUST BE COMPLETED PRIOR TO PERMITTING

List all food items to be prepared and distributed.-Only foods that are non-potentially hazardous are allowed.

Residential Wholesale Operations are not allowed.

## RESIDENTIAL KITCHEN 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 #: \_\_\_\_\_