

# TOWN OF ROCKLAND

## Board of Health

Town Hall  
242 Union Street  
Rockland, Massachusetts 02370

Dear Applicant:

Enclosed is your application for Food Establishment for 2018 which is required each year for consideration. Applications must be filed with the Board of Health Office by **December 08, 2017**.

Please provide the following documents:

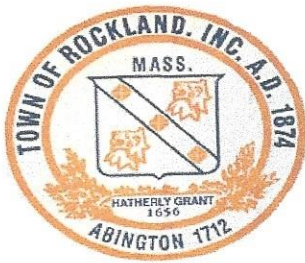
- Completed Workers' Compensation Affidavit
- Certificate of General Liability Insurance
- Certificate of Workers Comp Liability
- Check made payable to the Town of Rockland in the appropriate amount
- Copy of Food Service Manager Certification
- Copy of Food Allergen Awareness Certificate:

*It is important the applicant signs and completes all sections of application, incomplete applications will be returned. Any business that has not secured their permits by **December 31, 2017** will be considered "**Out of Business**", operating without a license and must start the entire process of submitting plans and filing a new application to operate a Food Establishment in the Town of Rockland. **NO Exceptions***

Thank you for your prompt attention to this matter. If you have any questions, please contact me at (781) 616-6815

Sincerely,

Delshaune R. Flipp  
Sr. Assistant



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### 2018 application for Permit to Operate a Food Establishment

Date: \_\_\_\_\_ FID #: \_\_\_\_\_

Legal Business Name: \_\_\_\_\_

DBA: \_\_\_\_\_

Business Address: \_\_\_\_\_

Mailing address: \_\_\_\_\_

Name of Owner: \_\_\_\_\_

Address of Owner: \_\_\_\_\_

Phone #: B: \_\_\_\_\_ C: \_\_\_\_\_ H: \_\_\_\_\_

Email Address: \_\_\_\_\_

If Corporation or Partnership provide Name, Title & Address

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

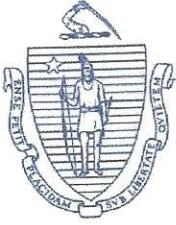
#### State of Incorporation

Name: \_\_\_\_\_ Title: \_\_\_\_\_

Address: \_\_\_\_\_

<u>Type of Establishment</u>	<u>Fee</u>	<u>Amount to be paid</u>
Food Service: 0 – 50 Seats	\$ 100.00	\$ _____
Food Service: 51 – 75 Seats	\$ 125.00	\$ _____
Food Service: Over 75 Seats	\$ 150.00	\$ _____
Retail Food	\$ 125.00	\$ _____
**Mobile Food	\$ 100.00	\$ _____
Residential	\$ 100.00	\$ _____
Catering (Annual)	\$ 125.00	\$ _____
Catering (One Day)	\$ 50.00	\$ _____
Soft Serve Ice Cream	50.00	\$ _____
Milk	\$ 10.00	\$ _____

Applicant's Signature \_\_\_\_\_



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017

www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.  
 TO BE FILED WITH THE PERMITTING AUTHORITY.

Please Print Legibly

**Applicant Information**

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 #: \_\_\_\_\_