



TOWN OF
CHESTER, MASSACHUSETTS

01011

BOARD OF HEALTH
15 Middlefield Road
Chester, MA 01011
413-354-7781
BoardofHealth@townofchester.net

**Temporary One Time Event/Festival Application for Permit to Operate
A Temporary Food Service Establishment**

Permit Fee \$50.00 For Profit OR \$30.00 Non-Profit

*Applications for this permit must be made (2) two weeks prior to the event

A temporary food establishment means any site where food is prepared and/or distributed for individual portion service. Temporary food establishment permits are required of each individual temporary food establishment that operates at a fixed site for a period of time not to exceed 14 consecutive days in conjunction with an event or celebration. The term temporary food service establishment shall apply to each separate site at an event or celebration. All temporary food service establishments must be ready for inspection at the start of the event.

Date: _____ Site Address: _____

Name of The Event: _____

Address Location of the Event: _____

Event Date: Start Date: _____ End Date: _____

Hours of Operation: Opening: _____ Closing: _____

Contact Person: _____

Booth/Unit Name: _____

Name of Owner: _____

Mailing Address: _____

Phone: _____ E-Mail: _____

What is the source of the food to be served/dispensed?

List the foods to be served/dispensed at the function

How will the food items be cooked?

How will the food item temperatures be kept?

Hot Holding?

Cold Holding?

How will the food be protected?

Describe the type/location of hand washing facility which will be used

Indicate water supply

Where will excess food and single service items be stored?

How will condiments and single serve items be dispensed?

What method of trash and garbage be used?

The above information is required to be submitted in accordance with chapter 10 of the state sanitary code 105 CMR 590.000. All applicants are required to abide by appropriate rules and regulations as identified by the state sanitary code. Pursuant to M.G.L. chapter 62C, section 49A, I the undersigned, certify under penalties of perjury that I, to my best knowledge and belief, have filed all state returns and paid all state taxes required under law.

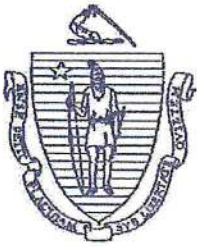
***Please submit serv safe and mass allergen certificates and certificate of insurance.**

Signature: _____ Date: _____

Print Name: _____

Social Security or Federal ID#: _____

Please refer to the website for additional requirements and/or contact the Board of Health at 413-354-7781 BoardofHealth@townofchester.net. Checks are to be made payable to the Town of Chester for all permit fees.



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 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 an 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 #: _____