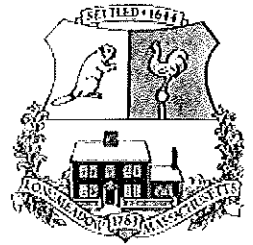


*town of*  
**LONGMEADOW, MASSACHUSETTS**

*phone: (413) 565-4140      20 Williams Street      01106*



BOARD OF HEALTH

- MICHAEL COPPOLA, M.D.
- BARRY IZENSTEIN, M.D.
- ROBERT RAPPAPORT, D.M.D.
- RICHARD STEINGART, M.D.
- MARY P. TOYE, R.N., M.S.

BEVERLY S. HIRSCHHORN, CHIO, MPH  
Health Director

**APPLICATION FOR REGISTRATION BY RETAIL FOOD ESTABLISHMENT**

**In accordance with the provisions of the Regulation promulgated under authority of Section 305.A of Chapter 94 of the General Laws of the Commonwealth of Massachusetts, application for Registration is hereby made by:**

\_\_\_\_\_ Firm Name \_\_\_\_\_ Firm Address  
Store Address \_\_\_\_\_

Type of Business: Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ Sole Owner \_\_\_\_\_

Name of Corporate Officers (to be signed by each):

President \_\_\_\_\_

Name

Address

Treasurer \_\_\_\_\_

Name

Address

Clerk \_\_\_\_\_

Name

Address

Name of Partners (to be signed by each):

Name

Address

Name

Address

Name of Sole Owner (to be signed): \_\_\_\_\_

Name, address, telephone & title of individual responsible for day-to-day operations:

Name, address, telephone & title of supervisor responsible for day-to-day operations:

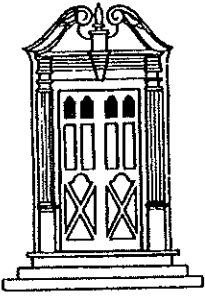
Name (s) of "Certified Food Protection Manager":

Signature of person preparing application \_\_\_\_\_

Date

Home Address \_\_\_\_\_

Store sells: Meat \_\_\_\_\_ Produce \_\_\_\_\_ Dairy \_\_\_\_\_ Dry Grocery \_\_\_\_\_ Frozen Food \_\_\_\_\_



*town of*  
**LONGMEADOW, MASSACHUSETTS**

*phone: (413) 565-4140    20 Williams Street    01106*



BEVERLY S. HIRSCHHORN, CHO, MPH  
Health Director

BOARD OF HEALTH

- MICHAEL COPPOLA, M.D.
- BARRY IZENSTEIN, M.D.
- ROBERT RAPPAPORT, D.M.D.
- RICHARD STEINGART, M.D.
- MARY P. TOYE, R.N., M.S.

**LONGMEADOW BOARD OF HEALTH**

**STATEMENT OF YEARLY GROSS INCOME**

Please check one of the following sales figures signifying the yearly gross income of your business as the basis for paying the proper Board of Health license fee/s to the Town of Longmeadow.

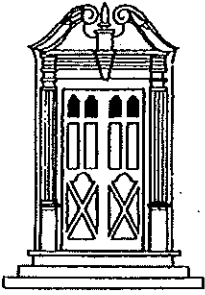
Type of License	Fee	Yearly Gross Income Sales
Food Service	\$195.00	\$200,000
	\$725.00	\$200,000- \$1,000,000
	\$1125.00	\$1,000,000
Retail Food	\$195.00	\$200,000
	\$725.00	\$200,000- \$1,000,000
	\$1125.00	\$1,000,000
Bakery	\$150.00	\$200,000
	\$375.00	\$200,000 - \$1,000,000
	\$725.00	\$1,000,000

Under the penalties of perjury, I do hereby certify that this form and statement is to the best of my knowledge, true, correct and complete. Information is subject to verification by the Longmeadow Board of Health.

\_\_\_\_\_  
Business Name \_\_\_\_\_  
Date

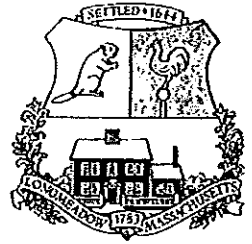
\_\_\_\_\_  
D/b/a (if any)

\_\_\_\_\_  
Owner of Corporate



*town of*  
**LONGMEADOW, MASSACHUSETTS**

*phone: (413) 565-4140 20 Williams Street 01106*



**BOARD OF HEALTH**

- MICHAEL COPPOLA, M.D.
- BARRY IZENSTEIN, M.D.
- ROBERT RAPPAPORT, D.M.D.
- RICHARD STEINGART, M.D.
- MARY P. TOYE, R.N., M.S.

BEVERLY S. HIRSCHHORN, CHO, MPH  
Health Director

**MANDATORY CERTIFICATION FOR APPLICANTS  
FOR BOARD OF HEALTH LICENSES**

**I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.**

\_\_\_\_\_  
Signature of Individual or Corporate Name  
(Mandatory)

\_\_\_\_\_  
By: Corporate Office Mandatory, if Applicable

\_\_\_\_\_  
Social Security or Federal Identification Number  
(Voluntary)

**Your license(s) will not be issued unless this certification clause is signed by the applicant.**

**Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass G.L.C. 62C. S.49A.**



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: LONGMEADOW 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: BEVERLY S. HIRSCHORN Phone #: (413) 565-4140