FEE $10.00

town of

LONGMEADOW, MASSACHUSETTS

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

APPLICATION FOR LICENSE TO MANUFACTURE FROZEN DESSERTS AND/OR ICE CREAM MIX

To the Board of Health of Longmeadow in accordance with the provisions of section 65H of Chapter 94 of the General Laws, as most recently amended, and the regulations made there under, the undersigned hereby applies for a license for the retail manufacture of frozen desserts and/or ice cream mix and submits the following information:

Name of applicant _____

Address _____

If applicant is an individual (name): _____
Address _____

If applicant is a partnership, name and address of all partners:
_____
_____

If applicant is a corporation:
State of incorporation _____
Date of incorporation _____
Principal Office _____

Required Information:

1. Name(s) of supplier of frozen dessert mix:
   _____
2. Brand or trade name(s) under which frozen dessert products are sold:
   _____
   _____
   _____

Certification

1. The undersigned applicant certifies that the frozen dessert products manufactured under this license are produced under sanitary conditions from pure and wholesome ingredients.
2. The applicant will submit test results of bacteriological tests on at least one dairy-based frozen dessert product per month performed by a laboratory approved by the Mass. Dept. of Public Health.
3. Bacterial testing results submitted should consist of (1) a count of coliform colonies/gram and a (2) "standard plate count"/gram. In the case of frozen yogurts containing active yogurt cultures, only the coliform test (1) is required.

Signature _____ Date _____

town of

LONGMEADOW, MASSACHUSETTS

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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.

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 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: 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. HIRSCHHORN Phone #: (413) 565-4140