TOWN OF DEERFIELD
Board of Health

FOOD SERVICE ESTABLISHMENT APPLICATION

FEE: **$200.00**

Owner's Name: _____ *Date:*_____

Address: _____

Email: _____

Person-in-Charge: _____

PIC Email & Phone: _____

Telephone Number: _____ *Fax:* _____

Federal Employer Identification Number (required): _____

Signature of Applicant: _____

The Social Security and/or Federal Tax Identification 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 notification is made under the authority of M.G.L. Ch. 62C, Sec. 49A.

All Deerfield residents or property owners must complete this section. The Town of Deerfield reserves the right to deny or revoke any permit to residents that have not provided the requisite information.
This requirement is waived for out of town applicants.

I, _____ the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and that all taxes and fees due the Town of Deerfield have been paid or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY, this _____ day of _____, 20 ___.

_____ _____
Signature of Taxpayer By: Corporate Officer (if applicable)

Collector's Acknowledgement: ***By:*** _____
Office of the Collector/Treasurer/Town Clerk

Date of Issuance: _____

Mail form with appropriate fee (and make checks payable) to:

Returned check fee is $25.00.

Town of Deerfield
Board of Health
8 Conway Street
S Deerfield MA 01373

REINSTATEMENT OF LAPSED PERMIT(S) IS DOUBLE THE CURRENT FEE.

For BOH Office Use Only:
Application Number(s): _____ Permit Number(s): _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette, Boston, MA 02111-1750
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 § 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 (check one):

1.☐ Board of Health 2.☐ Building Department 3.☐ City/Town Clerk 4.☐ Licensing Board
5.☐ Selectmen's Office 6.☐ Other _____

Contact Person: _____ **Phone #:** _____