



**TOWN OF WEST SPRINGFIELD
HEALTH DEPARTMENT**

26 Central Street, Suite 18
West Springfield, MA 01089-2754
Phone: (413) 263-3206 FAX: (413) 737-1583

Fee \$ _____
(See Page 2)

**Application for Permit to Operate a Temporary Food
Establishment on the Eastern States Exposition Grounds**

Date: _____

Name of Establishment: _____

Business Address: _____

Mailing Address (if different): _____

Phone Number: _____ Fax Number: _____

Name & Title of Applicant: _____

Name of Owner (if different from applicant): _____

If corporation or partnership, give name, title & home address of offices or partners.

<u>Name</u>	<u>Title</u>	<u>Home Address</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

State of Incorporation: _____ Name & Address of Local Agent: _____

Name of Event on the Eastern States Exposition Grounds _____

Date(s) of Event on the Eastern States Exposition Grounds _____

Hours of Operation:

_____ Sunday _____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday _____ Saturday

Purpose of Permit: _____
(types of food)

Food Safety Manager _____ **Expiration Date:** _____

Required by state and local regulations.

If Restaurant: Number of Seats _____

Person Trained in Anti-Choking Procedures (if 25 seats or more). _____ Yes _____ No

Signature of Applicant

See other side →

**Application for Permit to Operate a Temporary Food Establishment
on the Eastern States Exposition Grounds**

Pursuant to M.G.L. Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

Social Security Number or Federal Identification Number

Signature of Individual or Corporate Name

by

Corporate Officer (if applicable)

Fee Schedule

Events 1 to 3 days in length - \$25.00
Events 4 to 10 days in length - \$50.00
Events over 10 days in length - \$75.00

For Board of Health Use Only

Date Received

Date Inspected

Approved By

Permit # Issued
