



Hadley Board of Health

100 Middle Street 1st Floor Hadley, MA 01035

Email - health@hadleyma.org

Phone - 413-584-4562



Public Health
Prevent. Promote. Protect.

APPLICATION TO OPERATE A FOOD ESTABLISHMENT

Mail: Completed application & payment for annual permit payable to "Town of Hadley"
to the: Town of Hadley – Board of Health 100 Middle Street Hadley, MA 01035

Name of Establishment: _____

Owner Name: _____

Location Address: _____

Mailing Address (if different): _____

Telephone at Establishment: _____ Email: _____

Name & Title of Applicant: _____

Address of Applicant: _____

Name of Owner (if different than applicant): _____

A Individual *B Partnership *C Corporation *D Association *E Other explain _____

*if B, C, D, or E circled – provide: Name, Title, Phone #, and Home Address of Officers/Partners

Emergency Response Person or Zone, District, Regional Manager:

Name: _____ Telephone Number: _____

Address: _____ Email: _____

Manager of Food Establishment:

Name: _____ Telephone Number: _____

Address: _____ Email: _____



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Type of Food Establishment – check all that apply

- | | |
|--|--|
| <input type="checkbox"/> Food Service | <input type="checkbox"/> Caterer |
| <input type="checkbox"/> Retail Food | <input type="checkbox"/> Residential Kitchen |
| <input type="checkbox"/> Incidental Retail Food
(pre-packaged, non-refrigerated foods only) | <input type="checkbox"/> Institutional (ex. School, Skilled
Nursing Facility, Day Care) |
| <input type="checkbox"/> Mobile
(complete unit information sheet and other
permitting procedures as requested) | <input type="checkbox"/> Private Club, Church, Non-Profit |

Duration of Permit: **Annual** **Seasonal** **Temporary Event**
(must list all food and where it is from)

Days(s) and Hours of Operation/Temporary Event: _____

Seating Capacity: _____ **Square Footage (for Retail):** _____

*Temporary Event must list the food to be served and where it is from use an additional page if necessary

Person(s) Certified in:	Yes	No
Food Safety Management		
Allergen Awareness		
Anti-Choking Procedures - Services with seating capacity of 25 or more must have a certified employee on site for each shift		

All applicable certifications shall be posted in a conspicuous place

By signing this I attest to the accuracy of the information provided in this application. Furthermore, I affirm compliance with the provisions of 105CMR 590.000 Minimum Sanitation standards for Food Establishments and FDA 1999 Food Code and will operate and maintain the above described establishment in accordance with these regulations. I also allow the regulatory authority access as specified in this code.

Signature: _____ Date: _____

Signature of _____ Social Security or Federal ID #: _____
Corporate Officer (if applicable)

Pursuant to M.G.L. Ch. 62C., Sec.49A, 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.