

FOR BOARD OF HEALTH USE ONLY App #: _____

Check# _____ Fee Paid _____ Approved By _____

Permit #: _____

Receipt # _____

TOWN OF WAYLAND

Ice Cream Truck FOR ONE TEMP EVENT

BOH Application fee is **\$35.00**; make check payable to Town of Wayland; payment must accompany Application. A completed Workers Comp Affidavit must be completed if you are claiming an exemption or a Workers Comp Cert Page must be attached if you carry workers comp. **CORI documentation must be provided for our Police Chief to approve drivers along with truck registration and insurance information.**

1) Establishment Name:													
2) Establishment Address:													
3) Establishment Telephone No:	Fax No:												
4) Establishment Mailing Address (if different):													
5) Telephone No. at Mailing Address:	Fax No:												
6) Applicant Name & Title:													
7) Applicant Address:													
8) Applicant Telephone No:	24 Hour Emergency No:												
9) Applicant email address:													
10) Owner Name & Title (if different from applicant):													
11) Owner Address (if different from applicant):													
Email:													
12) Establishment Owned By:	13) If a corporation or partnership, give name, title, and home address of officers or partner.												
<input type="checkbox"/> An association <input type="checkbox"/> A corporation <input type="checkbox"/> An individual <input type="checkbox"/> A partnership <input type="checkbox"/> Other legal entity _____	<table><thead><tr><th><u>Name</u></th><th><u>Title</u></th><th><u>Home Address</u></th></tr></thead><tbody><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr><tr><td>_____</td><td>_____</td><td>_____</td></tr></tbody></table>	<u>Name</u>	<u>Title</u>	<u>Home Address</u>	_____	_____	_____	_____	_____	_____	_____	_____	_____
<u>Name</u>	<u>Title</u>	<u>Home Address</u>											
_____	_____	_____											
_____	_____	_____											
_____	_____	_____											
14) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager etc.)													
Name & Title:													
Address:													
Telephone No:	Fax No:												
Emergency Telephone No:													
Email Address:													
15) District Or Regional Supervisor (if applicable)													
Name & Title:													
Address:													
Telephone No:	Fax No:												
Email Address:													

Food Establishment Information

16) Water Source: DEP Public Water Supply No: (<i>if applicable</i>)		17) Sewage disposal: 17b) Grease trap vendor & schedule:			
18) Days and Hours of Operation:		19) No. of Food Employees:			
20a) Person In Charge Certified in Food Protection Management and Date of Certification (5 yrs): Please attach copy of certificates.					
20b) Name of Person and Date of Allergy Video Certification (5 yrs): Please attach copy of certificates.					
21) Name of Person(s) Trained and Dates of Certification In Anti-Choking Procedures (if 25 seats or more (2yrs)): Please attach copy of certificates.					
22) Location: (check one) <input type="checkbox"/> Permanent Structure <input type="checkbox"/> Mobile		23) Establishment Type (check all that apply) <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; border: none;"> <input type="checkbox"/> Retail (_____ Sq. Ft) <input type="checkbox"/> Food Service – (_____ Seats) <input type="checkbox"/> Food Service – Takeout <input type="checkbox"/> Food Service – Institution (_____ Meals/Day) </td> <td style="width: 50%; border: none;"> <input type="checkbox"/> Caterer <input type="checkbox"/> Food Delivery <input type="checkbox"/> Residential Kitchen for Retail Sale <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Establishments <input type="checkbox"/> Frozen Dessert Manufacturer </td> </tr> </table>		<input type="checkbox"/> Retail (_____ Sq. Ft) <input type="checkbox"/> Food Service – (_____ Seats) <input type="checkbox"/> Food Service – Takeout <input type="checkbox"/> Food Service – Institution (_____ Meals/Day)	<input type="checkbox"/> Caterer <input type="checkbox"/> Food Delivery <input type="checkbox"/> Residential Kitchen for Retail Sale <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Home <input type="checkbox"/> Residential Kitchen for Bed and Breakfast Establishments <input type="checkbox"/> Frozen Dessert Manufacturer
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24) Length Of Permit: (check one) <input type="checkbox"/> Annual <input type="checkbox"/> Seasonal/Dates: _____ <input type="checkbox"/> Temporary/Dates/Time: _____		Other (Describe)			
25) Food Operations: (check all that apply):		Definitions: <i>PHF – potentially hazardous food(time/temperature controls required)</i> <i>Non-PHF – non- potentially hazardous food (no time/temperature controls required)</i> <i>RTE – ready-to-eat foods (Ex. sandwiches, salads, muffins which need no further processing)</i>			
<input type="checkbox"/> Sale of Commercially Pre-Packaged Non-PHF's	<input type="checkbox"/> PHF Cooked To Order	<input type="checkbox"/> Hot PHF Cooked and Cooled or Hot Held for More Than a Single Meal Service.			
<input type="checkbox"/> Sale of Commercially Pre-Packaged PHF's	<input type="checkbox"/> Preparation Of PHF's For Hot And Cold Holding For Single Meal Service.	<input type="checkbox"/> PHF and RTE Foods Prepared For Highly Susceptible Population Facility			
<input type="checkbox"/> Delivery of Packaged PHF's	<input type="checkbox"/> Sale Of Raw Animal Foods Intended to be Prepared by Consumer.	<input type="checkbox"/> Vacuum Packaging/Cook Chill			
<input type="checkbox"/> Reheating of Commercially Processed Foods For Service Within 4 Hours.	<input type="checkbox"/> Customer Self-Service	<input type="checkbox"/> Use Of Process Requiring A Variance And/Or HACCP Plan (including bare hand contact alternative, time as a public health control)			
<input type="checkbox"/> Customer Self-Service Of Non-PHF and Non-Perishable Foods Only.	<input type="checkbox"/> Ice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Offers Raw Or Undercooked Food Of Animal Origin.			
<input type="checkbox"/> Preparation Of Non-PHF's	<input type="checkbox"/> Juice Manufactured and Packaged for Retail Sale	<input type="checkbox"/> Prepares Food/Single Meals for Catered Events or Institutional Food Service			
Other (Describe):		<input type="checkbox"/> Offers RTE PHF in Bulk Quantities	<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
<input type="checkbox"/> Retail Sale of Salvage, Out-of Date or Reconditioned Food					

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable law. I have been instructed by the Board of Health on how to obtain copies of 105 CMR 590.000 and the federal Food Code.

26) Signature of Applicant: _____

27) Social Security Number or Federal ID: _____

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

28) Signature of Individual or Corporate Name: _____