



Town of Arlington  
 Department of Health and Human Services  
 Office of the Board of Health  
 27 Maple Street  
 Arlington, MA 02476

Tel: (781) 316-3170  
 Fax: (781) 316-3175

### Application for Permit to Operate a Food Establishment

Name of Establishment: \_\_\_\_\_

Tel #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Email: \_\_\_\_\_

Establishment Address: \_\_\_\_\_

Mailing Address (If Different): \_\_\_\_\_

Name and Title of Applicant: \_\_\_\_\_

Address of Applicant: \_\_\_\_\_

Name and Address of Owner \_\_\_\_\_  
 (If different from applicant)

Emergency Response Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Partner or Corporate Name (List Partners Below):**

Name	Title	Home Address

Number of Seats: \_\_\_\_\_ Hours of Operation: \_\_\_\_\_ Is a dumpster used? Yes No

If yes, provide Contractor Name: \_\_\_\_\_

Certified Food Manager: \_\_\_\_\_ (attach copy of certificate)

Employee (s) Trained in Allergen Awareness: \_\_\_\_\_ (attach copy of certificate)

Employee (s) certified in choke saving: \_\_\_\_\_ (attach copy of certificate)

Type of Service: (Circle all that apply) Sit Down Meals Take out Caterer Grocery Convenient Store

<u>Type of Establishment</u>	<u>Fee</u>	<u>Amount Due</u>
Category Risk Level 1	\$100.00	_____
Category Risk Level 2	\$200.00	_____
Category Risk Level 3	\$300.00	_____
Category Risk Level 4	\$400.00	_____

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_