



TOWN OF WINTHROP BOARD OF HEALTH

100 Kennedy Drive, Winthrop, MA 02152 Telephone: 617-846-1740 Fax: 617-539-5826

William Schmidt, Chairman BA, MPA, MAC
Dr. Astrid Weins, Vice Chairman
Susan Maguire, Member

Food Establishment Application

Complete EVERY field; if field is not applicable, type N/A. Incomplete applications will be returned

Date:	
Establishment Name:	
Establishment Address:	
Mailing address (if different):	
Establishment phone #:	
Name and Title of Applicant:	Phone #:
Owner Name (if different from applicant):	
Owner Address (if different from applicant):	
Owner phone #:	
Establishment owned by: (check one and provide name, title & home address of partners)	
<input type="checkbox"/> Association <input type="checkbox"/> Corporation <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Other Legal Entity	
Name of Certified Food Manager:	
Certificate #:	Expiration Date:
Provide a copy of your Food Safety Certification with this application.	
Person trained in anti-choking procedure (if 25 seats or more):	
Person responsible for daily operations (Owner, Manager, etc.):	
Name & Title:	
Address:	
Telephone #	
Rubbish Disposal provider:	
Grease Rendering/Disposal provider:	
Are you a caterer? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Do you sell containers of milk? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Are you a manufacturer of Frozen Desserts? Yes <input type="checkbox"/> No <input type="checkbox"/>	

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.

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 state taxes required under law.

Federal Identification #: _____

Signature of Applicant: _____ Date: _____

Mail this application, and copies of your ServSafe, and ChokeSafe certifications to:
Winthrop Health Department, 100 Kennedy Drive, Winthrop MA. 02152
Make check payable to Town of Winthrop, All fees are non-refundable.