CITY OF WALTHAM

MASSACHUSETTS

BOARD OF HEALTH

JOHN P. ZUPPE
DIRECTOR OF PUBLIC HEALTH

FOOD ESTABLISHMENT_____CATERER_____2016

Establishment Name: _____

Establishment Address/Phone Number:_____

Mailing Address if different: _____

Owner/Home Address/Phone Number: _____

_____

Hours and days of operation:

_____

*******Certificate of Anti-Choking **required** for Establishments with **25 seats or more.**

*******One Person In Charge (PIC) **must** be on the premises at all times, and be certified in Safe Food Handling from a state sanctioned food safety program. A valid Serv Safe Certificate is **required.**

*******A valid Allergen Certificate is required.

I certify that all information contained herein is true and accurate to the best of my knowledge and belief. I also certify that I will notify the Waltham Health Department should any information contained herein change, be modified or found to be inaccurate. I hereby certify that I am familiar with, and agree to conduct business in this establishment in accordance with the Federal Food Code and 105 CMR 590.00.

SIGNATURE: _____

PRINT NAME: _____

**** Social Security Number or Federal ID Number**: _____

FEE: $220.00 – Checks payable to the City of Waltham

ADDRESS: 119 School Street, Waltham, MA 02451. PHONE: 781-314-3305

Date Received_____Approved_____Permit – Issued/Mailed_____

Check #_____Cash_____