



CITY OF SALEM, MASSACHUSETTS

BOARD OF HEALTH
120 WASHINGTON STREET, 4TH FLOOR
TEL. (978) 741-1800
FAX (978) 745-0343
JSCOTT@SALEM.COM

KIMBERLEY DRISCOLL
MAYOR

JOANNE SCOTT,
HEALTH AGENT

APPLICATION FOR A TEMPORARY FOOD SERVICE PERMIT

FEE: 1-3 DAYS = \$300 NON-PROFIT = \$25
4-7 DAYS = \$600
OVER 7 DAYS = >7 DIVIDED BY 7 X 600 = THE AMOUNT DUE.
(EXAMPLE: 14 DAYS DIVIDED BY 7 = 2 X 600 = \$1200)
CHECK PAYABLE TO THE CITY OF SALEM, NO CASH

NAME OF EVENT _____ LOCATION _____

DATE(S) OF EVENT _____

NAME OF APPLICANT _____ TELEPHONE# _____

ADDRESS _____

NAME OF BUSINESS _____ TELEPHONE# _____

ADDRESS _____

CERTIFIED FOOD MANAGER'S NAME _____ CERTIFICATION# _____

A PLAN OF THE ESTABLISHMENT IS: _____ ENCLOSED _____ DRAWN ON THE BACK

TYPE OF REFRIGERATION: _____ GAS _____ ICE _____ DRY ICE _____ OTHER

METHOD FOR COOKING/HOT HOLDING: _____ GAS _____ OTHER

METHOD FOR SANITIZING: _____ CHEMICAL _____ OTHER

SOURCE OF FOOD: NAME: _____ ADDRESS _____

FOODS TO BE SERVED INCLUDING INGREDIENTS AND METHOD OF PREPARATION: _____

I HAVE READ THE BOARD OF HEALTH, "REQUIREMENTS FOR TEMPORARY FOOD ESTABLISHMENTS." I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS REGARDING THOSE REQUIREMENTS. I UNDERSTAND THEM, AGREE TO ABIDE BY THEM AND UNDERSTAND THAT FAILURE TO DO SO WILL RESULT IN REVOCATION OF MY TEMPORARY FOOD ESTABLISHMENT PERMIT.

PERSUANT TO MGL C62C, S49A, 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.

SIGNATURE

DATE

SOCIAL SECURITY OR FEDERAL ID #