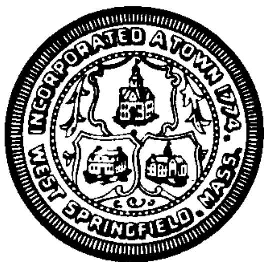

TOWN OF WEST SPRINGFIELD
HEALTH DEPARTMENT

26 Central Street, Suite 18
West Springfield, MA 01089-2754
Phone: (413) 263-3206 FAX: (413) 737-1583

Fee $ ________
(See Page 2)

Application for Permit to Operate a Temporary Food Establishment on the Eastern States Exposition Grounds

Date: ____________________________

Name of Establishment: ____

Business Address: ____

Mailing Address (if different): ____

Phone Number: ______________________________ Fax Number: ____________________________

Name & Title of Applicant: ____

Name of Owner (if different from applicant): ____

If corporation or partnership, give name, title & home address of offices or partners.

Name	Title	Home Address

State of Incorporation: ____________ Name & Address of Local Agent: ____________________________________

Name of Event on the Eastern States Exposition Grounds ____________________________________

Date(s) of Event on the Eastern States Exposition Grounds ____________________________________

Hours of Operation:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
________	________	________	________	________	________	________

Purpose of Permit: ____
(types of food)

If Restaurant:

Number of Seats ____________

Food Safety Manager ______________________________ Expiration Date: ____________________

Person Trained in Anti-Choking Procedures (if 25 seats or more). ______ Yes ______ No

____
Signature of Applicant

See other side ⟶

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 all state taxes required under law.

____ ____

Social Security Number or Federal Identification Number   Signature of Individual or Corporate Name

by ____

Corporate Officer (if applicable)

Fee Schedule

Events 1 to 3 days in length - $25.00
Events 4 to 10 days in length - $50.00
Events over 10 days in length - $75.00

For Board of Health Use Only

Date Received	Date Inspected	Approved By	Permit # Issued
____________	____________	____________	____________