



# TOWN OF LUDLOW

## HEALTH DEPARTMENT

488 Chapin Street  
Ludlow, MA 01056  
(413) 583-5600 ext. 1271 TEL  
(413) 583-5689 FAX



**Public Health**  
Prevent. Promote. Protect.

### **Application for Food Related Permits for Bar, Church, and Residential Kitchen**

**Permit Fee: \$80**

#### **Type of Establishment:**

- ☐ Bar/Tavern (Limited Food Prep – skip section #4)
- ☐ Church/Religious Org. Food Service (skip section #4)
- ☐ Residential Kitchen

#### **1. Contact Information:**

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

Business Address: \_\_\_\_\_

Mailing (if different): \_\_\_\_\_

E-Mail: \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### **2. Owner, Corporation, or Partnership Information:**

Name: \_\_\_\_\_ Title: \_\_\_\_\_

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

E-Mail: \_\_\_\_\_ Phone Number: \_\_\_\_\_

#### **3. Required Documentation to Be Completed by All Applicants:**

- ☐ Copy of Food Manager Certification
- ☐ Copy of Allergen Awareness Certification
- ☐ Full menu of all items offered
- ☐ Anti-choking Certification\*\*\*

#### **4. Checklist to Be Completed by Residential Kitchen Permit Applicants ONLY:**

- ☐ Rough floor plan for kitchen and storage areas
- ☐ Example of food product label
- ☐ All products sold by a licensed Residential Kitchen must be non-potentially hazardous food; products must be shelf-stable
- ☐ Review attached Residential Kitchen Inspection Checklist for more information

**\*Permits will NOT be issued for incomplete applications; please ensure you have submitted all necessary documentation.**

**\*\*Any renewal application received after expiration date will be subject to a 50% late fee.**

**\*\*\*A person certified in anti-choking procedures must be provided in food establishments with 25 or more seats and must be on site at all times while food is being served**

**Please contact the Health Department with any questions.**

I hereby certify by signing this application that I am an owner or officer of the above business, and all the information provided is true and correct. I agree to comply with the applicable rules and regulations (105 CMR 590.000). I agree to allow the Health Department, or its agents, access to the establishment to provide all required information. I agree to pay all appropriate fees at the time of application submittal.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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**For Official Use Only**

Date: \_\_\_\_\_ Fee Paid: \$\_\_\_\_\_ Check #: \_\_\_\_\_ Permit #: \_\_\_\_\_

Date of Review: \_\_\_\_\_

Reviewed by: \_\_\_\_\_