



**TOWN OF WILBRAHAM**  
 240 Springfield Street  
 Wilbraham, Massachusetts 01095  
 Phone: 413-596-2800  
 FAX: 413-596-9256

**SUPPLEMENTARY APPLICATION  
 PERMIT TO OPERATE A FOOD ESTABLISHMENT**

Name of establishment: \_\_\_\_\_

Business address: \_\_\_\_\_

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

Name and title of applicant: \_\_\_\_\_

Address of applicant: \_\_\_\_\_

Name of owner (if different than applicant): \_\_\_\_\_

Telephone Number of applicant: \_\_\_\_\_ Telephone Number of owner: \_\_\_\_\_  
*(If different than applicant)*

If corporation or partnership, give names, titles and home addresses of officers or partners:

Name	Title in corporation	Home address

State of incorporation: \_\_\_\_\_ Name and address of local agent: \_\_\_\_\_

Emergency contact name and telephone: \_\_\_\_\_

Type of Establishment:  Retail  Organization/Institution  Caterer  Residential Kitchen  Bakery

Duration of permit:  annual  seasonal  temporary (submit additional application form)

If seasonal, dates of operation: \_\_\_\_\_

Water source: \_\_\_\_\_ Sewage disposal: \_\_\_\_\_

Days and hours of operation: \_\_\_\_\_

If restaurant, number of seats for patrons: \_\_\_\_\_ Number of non-smoking seats: \_\_\_\_\_

Name of person trained in anti-choking procedures (if 25 or more seats): \_\_\_\_\_

Name of "Person in Charge": \_\_\_\_\_  
**(must attach a certificate establishing training in safe food handling program meeting standards of the Commonwealth of Massachusetts Department of Public Health, for at least one supervisory person)**

Signature of applicant: \_\_\_\_\_

**For Board of Health use:**

Date application received:	Date inspected:
Inspected by:	Permit date and number:

