TOWN OF WEST SPRINGFIELD
HEALTH DEPARTMENT

26 Central Street, Suite 18
West Springfield, MA 01089-2754
Phone: (413) 263-3206 FAX: (413) 737-1583
www.west-springfield.ma.us

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)

_____

Food Safety Manager_____ **Expiration Date:**_____
Required by state regulations

Allergen Training Certification_____ **Expiration Date:**_____
Required by state regulations
www.mass.gov/dph/fpp

See other side →