



TOWN OF CHILMARK
CHILMARK, MASSACHUSETTS

Board of Health

401 Middle Road, P.O. Box 119
Chilmark, MA 02535
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Fax (508) 645-2110
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Hours: 8:30 am to 3:30 pm, M-F

Temporary Food Establishment Permit Application

This form must be submitted no less than 15 business days prior to the event date to allow enough time for Zoning Department sign-off.

Permit # 2023 -	Date:	Fee: \$10 pd
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Applicant:		
Address:		
Phone #	E-mail:	
Name/Location of the Event:		
Event date:	Hours:	to
Number of People to be Served: Highly-Susceptible? Y / N		

1. Food to be served: attach menu if necessary

List all foodstuffs below: Source

2. Preparation/Cooking Facilities: describe facilities, processes and equipment

On-site:

Off-Site Location/name of kitchen:

Certified? Y/N

3. Food Protection during Transport and Service: describe processes to protect food and maintain temperature during storage, display, and transportation

4. Personnel and food-safe practices: Designated, on-site PIC with Serv-Safe required except at bake sales

Number of staff assigned to food service:

Tasks assigned to food staff members: <i>demonstrate segregation of money handling, ready-to-eat food service and raw food handling:</i>
Name of on-site PIC is:
Measures to ensure hot/cold holding:
Measures of cook-temp of animal-origin food:

5. Additional Requirements:

Toilet/handwashing facilities
Refrigeration or ice for sensitive foods
Measures to avoid bare-hand contact with RTE foods on display (i.e. tongs, serving tissues, napkins, etc.)
Garbage/Rubbish:

Please note: Home canned foods and foods cooked or prepared in a home kitchen may NOT be offered at temporary food events. The only exception to this is for baked goods being offered at a bake sale for a non-profit agency. **Any potentially hazardous foods which are pre-cooked and pre-cooled off-site for service at the temporary food event MUST be prepared at a licensed food establishment.**

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Applicant Signature: _____ **Date:** _____

To be completed by the Board of Health and Zoning Department:

Zoning Official Signature _____ Date: _____

Board of Health Official Signature _____ Date: _____

Action Taken: *Approved:* ____ *Denied:* ____

Conditions for Approval/ Reasons for Denial:
