Application #

Town of Stoughton

BOARD OF HEALTH

MOBILE FOOD APPLICATION

Date: _____

Applicant's Information *(Owner of the Business shall be the applicant)*

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Company Name: _____

Title: _____

( ) Corporation ( ) Individual ( ) Other_____

( ) Association ( ) Partnership

If Corporation or Partnership; please complete:

Name	Title	Main Office Address *(Address, City, Sate, Zip)*	Phone #	Fax #	Mailing Address *(Address, City, Sate, Zip) If different than the main office address*
1.					
2.					
3.					
4.					

State of Incorporation: _____

Business Information

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Water and Sewer Information:

Water Supply: ( ) Public ( ) Water Supply On-site

Sewage Disposal: ( ) Public ( ) On-site Septic

Grease Hauler Company Name: _____ (**N/A** *indicate if not applicable*)

Septic Hauler Company Name: _____ (**N/A** *indicate if not applicable*)

Mobile Food Information *Per Truck/Push Cart*

Vehicle Information

Business Name on Vehicle: _____

Make of Vehicle: _____

Make of Vehicle: _____

State registration number: _____

Hawkers and peddlers number: _____ Expiration date: _____

STOUGHTON SALE LOCATIONS

ADDRESS	DAY	TIME

Food Protection Procedures:

Open flame: ( ) Yes ( ) No

Propane: ( ) Yes ( ) No

Do you sell potentially hazardous foods? ( ) Yes ( ) No

Food Product(s) cooked on truck ( ) Yes ( ) No

Method of keeping hot foot 140° F:
( ) Heated Unit; Explain: _____ ( ) Other; Explain: _____

Method of keeping cold foot 41° F:
( ) Ice; Explain: _____ ( ) Other; Explain: _____

Hot and cold running water provided? ( ) Yes ( ) No

Gloves worn when handling ready to eat foods? ( ) Yes ( ) No

Are you a certified food manager? ( ) Yes ( ) No

☐ Attach copy of certification

Location(s) of toilet and hand washing facilities

Addresses	Toilet **Y/N**	Hand Washing Facility **Y/N**

Commissary Information:

Commissary Name: _____

Commissary Address: (*If different from the Business Address City, State and Zip)*

Street: _____

City: _____ State: _____ Zip: _____

Commissary Tel #:_____

Fees Per Truck / Push Cart

( ) Application Process		$125.00
		$_____
( ) Serve Milk /Cream		$10.00
		$_____
	TOTAL	**$_____**

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I understand that I am to notify the Stoughton Board of Health, upon the termination of employee certified food manager.

I understand that I am to notify the Board of Health prior to making any changes to the facility structure/operation (ex. Equipment changes/additions, etc.).

I declare under penalty or perjury all the following: 1) The statements made on the application are true and correct; 2) I have knowingly and willfully made truthful statements and included factual documents in support of this application; 3) I have filed all state tax returns and paid all taxes required under law; 4) I cannot conduct business until the Board of Health Permit is obtained**.**

Federal Identification Number: _____

Date: _____

Print Name of Individual or Corporate/Corporate Officer: _____

Signature of Individual or Corporate Officer: _____

Initial:_____

Application #

FOR FFICE USE ONLY

Payment Type:
( ) Cash ( ) Check # _____ ( ) Money Order # _____

Date Payment Received: _____