

RETAIL ESTABLISHMENT CHECKLIST

Establishment Name: _____

APPROVALS/SIGNATURES

**** needed prior to submitting to Health Department****

- Building/Zoning-Town Hall (3rd Floor)
- DPW (Only if on Town Sewer) 131 Camelot Drive
- Collectors - Town Hall (2nd floor)

IDENTIFICATION

- Copy of driver's license

CONTRACTS/AGREEMENTS

- Pest Management company & contract
- Trash company & contract
- Insurance Dec page and Workers Compensation Affidavit
- Massachusetts Tobacco license (if applicable)
- Copy of Lease Agreement (if applicable)
- MA Dept of Revenue form signed

SITE PLAN

- All Food Equipment/Storage
- Employee lockers (or area for staff belongings)
- Bathroom Facilities (Employee use & Public use)
- Dumpsters/Trash Location

OFFICE USE ONLY

(check before issuing permits)

- ___ Inspectional Services
- ___ Sewer Department (if needed)
- ___ Collectors Department

Items in **RED** font require attachments
**TOWN OF PLYMOUTH PUBLIC HEALTH
DEPARTMENT**
508-747-1620 X10118
Fax: 508-830-4062
26 Court Street
Plymouth, Massachusetts 02360

Review Fee: SUPERMARKET/PLUS (≥ 1,001 sq. ft.) - \$200 LARGE (≥ 301 sq. ft., but ≤ 1000 sq. ft.) - \$150 MEDIUM (≥71 sq. ft., but ≤ 300 sq. ft.) - \$100 KIOSK (≤70 sq. ft.) - \$75

**RETAIL ESTABLISHMENT PLAN REVIEW APPLICATION SHOULD BE
SUBMITTED AT LEAST 14 DAYS PRIOR TO OPENING- NEW
CONSTRUCTION – 30 DAY NOTICE FOR PLAN REVIEW**

If your establishment will be preparing food, you must complete the Food Establishment Review

If your establishment will be selling tobacco, you must complete a Tobacco Sales Application

Retail Establishment Name: _____

Establishment Address: _____

Mailing Address: _____

Anticipated Date of Opening: _____

Email: _____

Establishment Phone Number: _____

Owner's Name: _____

Owner's Title: _____

Owner's Address: _____

Owner's Phone Number: _____

24-Hour Emergency Contact Number: _____

Establishment Owned As (choose one):

Individually * Partnership * Corporation * Association * Other: _____

(Copy of Secretary of State Business Summary: <https://corp.sec.state.ma.us/corpweb/CorpSearch/CorpSearch.aspx>)

Site Operations

Establishment Hours of Operation:

Sunday		Thursday	
Monday		Friday	
Tuesday		Saturday	
Wednesday			

Square Footage:

Retail Square Footage: _____ Storage/Office Square Footage: _____

Name of Person(s)-In-Charge (PIC) of Daily Operations: _____

Items in **RED** font require attachments

Food Operations (Please select all that apply):

Acronyms Key: PHF – Potentially Hazardous Food (time/temperature sensitive)

Non-PHF – Non-Potentially Hazardous Food (no time/temp requirements)

RTE – Ready to Eat Foods (Ex: salads/sandwiches/muffins)

Commercially Prepackaged Non-PHF	Commercially Prepackaged PHF	Produce – RTE
Dairy – PHF	Frozen Foods – PHF	Customer Self-Serve Coffee – PHF
Dry Goods – Non-PHF	Offers of RTE in Bulk	Customer Self-Service on Non-PHF and non-perishable foods only
Retail Sales of Out of Date or Reconditioned Foods	Ice Manufactured and Packaged for Re-Sale	Sale of Raw Animal Foods intended to be prepared by the customer
Other (Explain):		

Does each refrigerator and freezer have a thermostat? YES NO

Does your site plan have the following labeled clearly:

<input type="checkbox"/>	All freezers and refrigerators	<input type="checkbox"/>	Employee Lockers/Storage
<input type="checkbox"/>	Restrooms	<input type="checkbox"/>	Retail displays
<input type="checkbox"/>	Mop Sink	<input type="checkbox"/>	Food storage areas
<input type="checkbox"/>	Trash locations (inside & outside)	<input type="checkbox"/>	Any other additional items

Name of Private Waste Hauler: _____

If Recycling, Name of Company: _____

Name of Pest Management Company: _____

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

*Signature of Individual or Corporate Name (Mandatory)

By Corporate Officer (Mandatory if Applicable)

**Social Security Number (Voluntary) or Federal Identification Number

* This License will not be issued unless this certification clause is signed by the applicant.

** Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations.

Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of MGL C 62C s 49A

Items in RED font require attachments

- Massachusetts Worker's Compensation Insurance Affidavit completed.
(<https://www.mass.gov/doc/affidavits-for-general-businesses/download>)
- Worker's Compensation Insurance and Liability declaration page showing the policy number, expiration date, and Town of Plymouth listed.

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.00 and all other applicable laws. For copies of the Food Code, 105 CMR 590.00 I can go to the Massachusetts State Book Store, One Ashburton Place, Boston, MA or the Massachusetts State Website.

Federal ID Number or Social Security Number: _____

Signature of Applicant: _____

Signature of Individual or Corporate Name: _____

(if applicable)

Board of Health Approval: _____

Comments and/or Conditions:

(All approvals must be obtained BEFORE submitting to Health)

Building/Zoning Approval: _____ Date: _____

Sewer Department Approval: _____ Date: _____

(Sewer ONLY IF on Town Sewer; N/A for septic system)

Collectors Office - no outstanding debt: _____ Date: _____