TOWN OF HINGHAM

BOARD OF HEALTH
210 Central Street, Hingham, MA 02043-2762
(781) 741-1466 Fax (781) 804-2373
Email: HealthDirector@Hingham-Ma.gov

FARMERS MARKET FOOD SERVICE APPLICATION

To Be Submitted Two (2) Weeks before Farmers Mkt

Application Fee

$100 for returning vendors

$200 for new vendors

Please note that the fee covers BOTH the summer and winter sessions of the Farmer's Market

Please check and attach the following documentation:
Certified Food Manager_____
Allergen _____
Residential or Commissary Establishment License_____
Workers Comp Form_____

Name of Applicant/Owner: _____Tel #: ( )_____

Address of Applicant/Owner: _____Email: _____

Base of Opeations Address_____
(i.e. Commissary-Residential Kitchen, etc)

Occasion: Hingham Farmer's Market

List of Food:

_____

_____

FOOD PROTECTION: List equipment to be used, describe measures to protect food and maintain temperature during storage, display and transportation.

_____

_____

_____Date_____
Applicant/Owner (Signature indicates operation by Date and acceptance of any conditions listed)

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette, Boston, MA 02111-1750
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information **Please Print Legibly**

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: _____

Insurer's Address: _____

City/State/Zip: _____

Policy # or Self-ins. Lic. #_____ Expiration Date: _____

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under § 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to $250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: _____ Date: _____

Phone #: _____

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ **Permit/License #** _____

Issuing Authority (check one):

1. ☐ **Board of Health** 2. ☐ **Building Department** 3. ☐ **City/Town Clerk** 4. ☐ **Licensing Board**
5. ☐ **Selectmen's Office** 6. ☐ **Other** _____

Contact Person: _____ **Phone #:** _____