If Restaurant: Number of Seats ___________

Person Trained in Anti-Choking Procedures (if 25 seats or more). ☐ Yes ☐ No

Pursuant to M.G.L. Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

Social Security Number or Federal Identification Number

Signature of Individual or Corporate Name

by ______________________________
Corporate Officer (if applicable)

APPLICATIONS MUST BE RECEIVED IN THE OFFICE OF THE WEST SPRINGFIELD HEALTH DEPARTMENT NO LATER THAN <u>THIRTY (30) DAYS</u> BEFORE THE START OF THE EVENT.

Fee Schedule

Events 1 to 3 days in length - $25.00
Events 4 to 10 days in length - $50.00
Events over 10 days in length - $100.00

For Board of Health Use Only

Date Received	Date Inspected	Approved By	Permit # Issued