Town of Carlisle
Office of
BOARD OF HEALTH
66 Westford Street
Carlisle, MA 01741

Tel.: (978) 369-0283
Fax: (978) 369-4521

RESIDENTIAL KITCHEN PERMIT APPLICATION FEE:

Name of Applicant: _____

Address of Residential Kitchen: _____

Name of Business: _____

Residential Kitchen is located in a: House Apt/Condo [ ] Other [ ]

Phone Number: _____Email:_____

List food(s) that will be prepared in the residential kitchen:

_____

_____

_____

_____

List market name(s) (including street & town) where ingredients will be purchased from:

_____

_____

_____

Food will be sold to (check all that apply): Internet customers [ ] Retail Stores/Supermarket [ ]

Farmer's Market [ ] One Day Events (ex. Old Home Day) [ ]

Other (describe): _____

Equipment and Facilities

Number of Pets at Home: _____ Are laundry facilities located in the kitchen: yes [ ] no [ ]

What method will be used to clean and sanitize cooking equipment, utensils and tableware?

Manual Cleaning and Sanitizing [ ] or Mechanical Cleaning and Sanitizing [ ]

Type of sanitizer that will be used if manual cleaning: _____

Mechanical Dishwasher: Which method will be used to test internal temperature after final rinse?

Maximum Registering Thermometer [ ] or Heat Thermal Label [ ]

Potable Water Source:

Date Well tested: _____ Water Analysis provided: yes [ ] no [ ]

ServSafe Certification: yes [ ] no [ ] If certified, expiration date: _____
(Please provide a copy of the certification.)

Labelling

Provide a copy of your food label(s) with the application.

An inspection must take place before a permit is issued. Once the permit is issued the residential kitchen will be allowed to operate. The Health Agent will contact the applicant to schedule an inspection.

Pursuant to MGL Chapter 62C, § 49A, I certify under the penalties of perjury that to the best of my knowledge and belief have filed all State tax returns and paid all State taxes required under law.

_____
Signature Date

Office Use: Approved [ ] Rejected [ ] Conditional Approval [ ]

Comments:

_____ Date: _____
Health Agent