Food Establishment Plan Review Application

CHANGE IN EQUIPMENT/ MENU

Oak Bluffs Health Department

Name of Establishment: _____

Address of Establishment: _____

105 CMR 590.011 requires the Board of Health to deny or grant approval of food establishment plans within thirty (30) days upon submission of said plans. This thirty-day (30) time period begins when a **complete application** when all the paperwork has been submitted to the Health Department.

I, _____, have read and understand the contents/requirements of this application packet and agree to the provisions listed above and contained within.

Date_____

NO CHANGE IN EQUIPMENT IS PERMITTED IN FOOD ESTABLISHMENTS UNLESS APPROVED BY THE HEALTH DEPARTMENT

For Office Use Only:

Complete Plan Review Application Accepted by Health Department Date:
Reviewer's Signature

Oak Bluffs Health Department
Plan Review: Change in Equipment/Menu

Name of Establishment _____
Business Phone # _____
Business Address _____
Mailing Address (if different) _____
Name & Title of Applicant _____
Address of Applicant _____
If corporation or partnership, give title, name & address of officers or partners:

Name	**Title**	**Address & Telephone #**

Number of seats _____ Number of square feet _____
No. Of Staff (Maximum per shift) _____

EMERGENCY INFORMATION
We must be able to contact you in case of an emergency. We DO NOT WANT a corporate address. We require personal addresses where responsible people can be reached at any time.

NAME OF BUSINESS OR COMPANY _____
NAME OR OWNER AND/OR MANAGER _____
_____
ADDRESS _____
TELEPHONE # (OFFICE) _____
TELEPHONE # (EVENING/ 24 HOUR) _____

1ST ALTERNATE CONTACT _____
HOME ADDRESS _____
HOME TELEPHONE # _____

PERSON IN CHARGE (PIC) _____
ALTERNATE PERSON IN CHARGE (PIC) _____
ALTERNATE PERSON IN CHARGE (PIC) _____
CERTIFIED FOOD PROTECTION MANAGER _____

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

Federal ID:_____ Or Social Security Number: _____

Signature of Individual or Corporate Name:_____

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 590.000 and all other applicable law. I have been instructed by the Board of Health on how to obtain copies of 105 CMR 590.000 and the Federal Food Code.

Signature _____

FOOD ESTABLISHMENT INFORMATION

Days & Hours of operation: _____

Meals to be served (circle all that apply): Breakfast Lunch Dinner

Number of food employees: _____

Name of Certified Food Protection Manager: _____

Name of person(s) trained in choke saver procedures (one per shift if over 25 seats):
_____

Location (permanent structure or mobile): _____

Length of Permit (annual or seasonal with dates of season): _____

Food Operations (Check all that apply):

_____Retail Sale of Commercially Pre-packaged Non-PHF's
_____Retail Sale of Commercially Pre-packaged PHF's
_____Preparation of PHFs for eat in or take out (CFPM required)
_____Offers RTE PHFs in Bulk Quantities (CFPM required)
_____PHFs Cooked to Order or Served Raw or Under Cooked (Consumer Advisory required)
_____Preparation of Food/Single Meals for Catered Event (CFPM required)
_____Preparation of Non-PHF's (coffee, hot dogs)
Use of a Process Requiring a Variance and/or HACCP Plan:
- _____Use of Un-pasteurized Shell Eggs Prepared for Highly Susceptible Population (variance & HACCP Plan needed)
- _____Use of food additives for preservation (i.e. Acidification of sushi) (variance & HACCP Plan needed)
- _____Smoking for Preservation (variance & HACCP Plan needed)
- _____Curing (variance & HACCP Plan needed)
- _____Custom Processing of Animals (variance & HACCP Plan needed)
- _____Molluscan Shellfish Tanks (variance & HACCP Plan needed)
- _____Reduced Oxygen Packaging with Barriers (ROP or Vacuum Packaging) (variance & HACCP Plan needed)
- _____Time as a Public Health Control (variance & HACCP Plan needed)
- _____Bare Hand Contact with RTEs (HACCP Plan needed)

Definitions:

PHF – potentially hazardous food (time/temperature controls required)
Non-PHF – non-potentially hazardous food (no time/temperature controls required)
RTE – ready-to-eat foods (ex. sandwiches, salads, muffins, French fries. etc. which need no further processing)
Highly Susceptible Population (HSP) - A group of persons who are more likely than other populations to experience food borne disease because they are immune-compromised, or older adults in a facility that provides health care or assisted living services, such as a hospital or nursing home, or children in day care or elementary school.
CFPM – Certified Food Protection Manager
Consumer Advisory – Written information concerning the safety of raw or undercooked food
HACCP Plan (Hazard Analysis Critical Control Point Plan) – Written document delineating HACCP principles in use
Variance – Written document issued by the Board of Health

INFORMATION NEEDED BEFORE CHANGE IN MENU:

1. Completed Food Establishment Plan Review Application for Change in Menu.

2. Include the following items with the completed application:

____ a) Menu, include all new proposed menu items

____ b) Floor plan: Show location of all equipment to determine food flow.

____ c) Site plan: Show location of equipment, garbage storage, and grease storage.

____ d) Manufacturer's Specification Sheet(s) for all new proposed equipment (indicate locations on floor plan)

____ e) Check for plan review fee (non-refundable) made out to "Town of Oak Bluffs"

3. Letter from Health Department approving the submitted application and change of menu plan. The letter will allow for change in menu plan. No menu changes are allowed without this letter.

Please call Oak Bluffs Health Agent, with questions: 508-693-6280 Ext 116.

EQUIPMENT SPECIFICATIONS

A. Specify Change In Equipment. Indicate type of proposed equipment, location of equipment. Use back page of this sheet if necessary.

_____
_____
_____
_____
_____
_____
_____

I hereby certify that the above information is correct, and I fully understand that any deviation from the above without prior permission from the office may nullify this approval.

Signature(s) _____

Date _____

Owner(s) or responsible representative(s)_____

Approval of these plans and specifications by this Health Department does not indicate compliance with any other code, law, or regulations that may be required (federal, state, or local). It further does not constitute endorsement or acceptance of the completed establishment (structure or equipment).

An inspection of the establishment with proposed menu changes and equipment will be necessary to determine if it complies with the local and state laws governing food service establishment.

OAK BLUFFS HEALTH DEPARTMENT

APPLICATION FOR CHANGE IN MENU/EQUIPMENT

REVIEWER'S COMMENTS

Reviewer's Comments: (Note why any item was "unacceptable.")

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Reviewer's Signature Date

_____
Reviewer's Title

Approval: _____ Date_____

Disapproval: _____ Date _____

Reason(s) for disapproval:

_____
_____
_____
_____
_____
_____
_____
_____