



Town of Lexington
Land Use, Health and Development Department
 Office of Public Health
 1625 Massachusetts Avenue
 Lexington, MA 02420
 (781)-698-4533
 Fax (781)-861-2780

Permit Number: _____
Issued Date: _____
Permit Fee: _____
Check #: _____

Gerard F. Cody, R.E.H.S./R.S.
 Health Director x 84503

Kathy P. Fox, R.E.H.S. /R.S., C.H.O., CP-FS
 Environmental Health Agent x 84507

David Neylon, B, S.N., R.N.
 Public Health Nurse x 84509

Board of Health
 Wendy Heiger-Bernays, PhD, Chair
 Sharon Mackenzie, R.N., CCM
 Burt M. Perlmutter, M.D.
 David S. Geller, M.D.
 John J. Flynn, J.D.

Application for Permit to Transport and/or Dispose of Rubbish/Refuse

Fee: \$100.00 **Current Permit Expires:** _____ **Permit #** _____

Business or Trade Name: _____

Business Address: _____

Mailing Address (if different): _____

Telephone # of Business: _____

Name and Title of Applicant: _____

Address of Applicant: _____

Telephone # of Applicant: _____

E-mail Address: _____

Name of Owner (if different from applicant): _____

If corporation or partnership, give name, title, home address, of partners below if more room is needed please attach information:

Name	Title	Home Address

Vehicle Registered to:	Vehicle Registration

Name and Address of Facility where Rubbish/Refuse is disposed of:

APPLICANT 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 of Owner and/or Manger: _____

Address (Home): _____

Telephone # (Home): _____

Telephone # (Cell/24 Hour): _____

E-mail Address: _____

1st Alternate Contact (Name): _____

Address (Home): _____

Telephone # (Home): _____

Telephone # (Cell/24 Hour): _____

E-mail Address: _____

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 _____

FOR BOARD OF HEALTH USE ONLY

Date Rec'd.	Date Inspected	Approved by	Permit #
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