TOWN OF ROCKLAND
Board of Health
Town Hall
242 Union Street
Rockland, Massachusetts 02370

APPLICATION TO PARTICIPATE OR OPERATE SPACE AS A VENDOR AT A FARMERS MARKET

An application to operate or participate in a Farmers Market in the Town of Rockland is required each year for consideration. Applications must be filed with the Board of Health Office.

Please provide the following documents: (checking off the boxes below ensures all supporting documents are enclosed)

- Completed signed Application.

- Insurance Information
  - ☐ Completed Workers' Compensation Affidavit
  - ☐ Certificate of Workers Comp Liability (if applicable)
  - ☐ Certificate of General Liability Insurance

  All Insurance Certificates must include the Town of Rockland as a certificate holder:
  The Town of Rockland BOH, 242 Union St Rockland, MA. 02370

- **Certificates**
  - ☐ Serve Safe Manager Certificate
  - ☐ Allergen Awareness Certificate
  - ☐ Hawker / Peddler
  - ☐ CORI / SORI (ice cream trucks)

- **Miscellaneous**
  - ☐ Menu
  - ☐ Commissary approval letter from establishment
  - ☐ Commissary Permit & Inspection
  - ☐ Copy of Most Recent Permit & Inspection from current Town (if applicable)
  - ☐ Check made payable to the Town of Rockland in the appropriate amount

It is important the applicant signs and completes all sections of application, incomplete applications will be returned. Any business that does not secure their permits will be considered **"*Out of Business*",** operating without a license and must start the entire process of submitting plans and filing a new application to operate or participate in a Farmers Market in the Town of Rockland. ***NO Exceptions.***

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Application for Permit to Operate or Participate Farmers Market

Date: _____ **FID #:** _____

Legal Business Name: _____

DBA: _____

Business Address: _____

Mailing address: _____

Name of Owner: _____

Address of Owner: _____

Phone #: B: _____ **C:** _____ **H:** _____

Email Address: _____ **(*PRINT CLEARLY*)**

Type of Establishment	**Fee**	**Amount to be paid**
Farmers Market (Annual)	**$ 100.00**	**$**_____
Farmers Market (1 Day)	**$ 50.00**	**$**_____

Total Due: $_____

Applicant's Signature_____

(781) 871-1874 Ext.1005 Fax: (781) 871-2644

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

Applicant Information **Please Print Legibly**

Business/Organization Name: What the Pickles

Address: 176 Warren Ave

City/State/Zip: Plymouth MA 02360 Phone #: 408 230 7557

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 Section 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 (circle one):
1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
6. Other _____

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