

SOUTHBOROUGH BOARD OF HEALTH FOOD SERVICE INFORMATION SHEET

Name of Establishment	Address of Establishment	Phone # of Establishment																					
Name of Person Completing Form:	Date Form Completed:	Food Service Manager:																					
No. of Seats _____	No of Employees _____																						
Hours Days: _____	Days of Wk	Months of Year																					
Evenings: _____																							
Names of Personnel Trained in ChokeSaver Techniques, Date Trained & Work Schedule. <table style="width:100%; border:none;"> <tr><td style="width:33%; border:none;">_____</td><td style="width:33%; border:none;">_____</td><td style="width:33%; border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> <tr><td style="border:none;">_____</td><td style="border:none;">_____</td><td style="border:none;">_____</td></tr> </table>			_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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Attach additional sheets if necessary _____																							
Name & Address of Rubbish Hauler:	Name & Address of Pesticide company:	Name & Address of Septic Hauler: Grease Hauler (if different):																					
Water Supply:	Town: _____	Well: _____																					
Square feet of Seating Total: _____	Square feet of Non-Smoking Seating: _____	Square feet of Kitchen: _____																					
Square feet of Walk-In Refrigeration: _____	Square feet of Walk-In Freezer Space: _____	Square feet of Dry Storage Space: _____																					