



TOWN OF MARION
BOARD OF HEALTH
2 SPRING STREET
MARION, MA 02738
508-748-3530

2023

**Tobacco Products and Nicotine Delivery Products
Annual Sales Permit Application**

(Application must be submitted at least 30 days before the planned opening date)

1) Establishment Name:																	
2) Establishment Address:																	
3) Establishment Mailing Address (if different):																	
4) Establishment Telephone No:		Fax No:															
5) Applicant Name & Title:																	
6) Applicant Address:																	
7) Applicant Telephone No:	24 Hour Emergency No:	Email:															
8) Owner Name & Title (if different from applicant):																	
9) Owner Address (if different from applicant):																	
10) Establishment Owned by: _____ An association _____ A corporation _____ An individual _____ A partnership _____ Other legal entity		11) If a corporation or partnership, give name, title and home address of officer(s) or partner(s): <table border="1"><thead><tr><th><u>Name</u></th><th><u>Title</u></th><th><u>Home Address</u></th></tr></thead><tbody><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr><tr><td> </td><td> </td><td> </td></tr></tbody></table>	<u>Name</u>	<u>Title</u>	<u>Home Address</u>												
<u>Name</u>	<u>Title</u>	<u>Home Address</u>															
12) Person Directly Responsible For Daily Operations (Owner, Person in Charge, Supervisor, Manager, etc.)																	
Name & Title:																	
Address:																	
Telephone No:	Fax:	Email:															
Emergency Telephone No:																	
13) District or Regional Supervisor (if applicable)																	
Name & Title:																	
Address:																	
Telephone No:	Fax:	Email:															
For Board of Health Use Only																	
Check #:	Date:	Amount:															

Tobacco Retailer Information

14) Style of Establishment : (Check only one) <input type="radio"/> Adult-Only Retail Tobacco Store <input type="radio"/> Bar <input type="radio"/> Convenience Store <input type="radio"/> Gas Station Only <input type="radio"/> Liquor Store <input type="radio"/> Membership Association <input type="radio"/> Gas Mini-Mart <input type="radio"/> Other (specify):	
16) Days and Hours of Operation:	
18) Number of Employees Selling Tobacco and Nicotine Delivery Products:	
19) Products Sold- <input type="radio"/> Chew Tobacco <input type="radio"/> Cigarettes <input type="radio"/> Cigarillos <input type="radio"/> Cigars <input type="radio"/> Dissolvable Tobacco <input type="radio"/> Little Cigars <input type="radio"/> Pipe/Loose Tobacco <input type="radio"/> Other (List):	
20) I have read, understand, and completed the Marion Board of Health's Tobacco Products and Nicotine Delivery Sales Permit Acknowledgment and Checklist Form. Initials: _____	
21) I have read the Marion regulation and will train sales staff/employees about this regulation and to conduct tobacco and nicotine delivery product sales legally. Initials _____	
22) I understand that this Tobacco and Nicotine Delivery Products Permit is non-transferable by establishment owner or by location and expires each year on December 31st . A permit will not be renewed if the permit holder has failed to pay all fines issued and the time period to appeal the fines has expired. Initials _____	
23) I understand that before a permit will be issued, I must submit the following documents with this Tobacco Products and Nicotine Delivery Products Sales Permit Application. <input type="checkbox"/> Copy of my current Massachusetts Department of Revenue Tobacco Retailer's License <input type="checkbox"/> Current Workers Compensation Affidavit (I have attached the above documents to this application) Initials _____	
License to Sell Tobacco Products	\$ 75.00

As the owner, manager, and / or operator who holds a State License to sell TOBACCO products, I hereby apply for a Marion Board of Health TOBACCO PRODUCTS and NICOTINE DELIVERY PRODUCT Permit with the understanding that it is illegal to sell TOBACCO/NICOTINE DELIVERY PRODUCTS in any form to individuals under 21 years of age. I am aware that there are no exceptions. I will obtain government issued photographic proof of age from all customers who look to be 27 years of age or younger before selling any TOBACCO/NICOTINE DELIVERY PRODUCTS. TOBACCO/NICOTINE DELIVERY PRODUCTS will be located to be in compliance with the Marion TOBACCO/NICOTINE DELIVERY PRODUCT Regulations. I understand that the Marion Board of Health and its agents will conduct unannounced compliance checks. I am aware that violations of any section for the TOBACCO/NICOTINE DELIVERY PRODUCT Regulation may result in issuance of fines and / or the revocation of this permit. I understand that this permit must be renewed annually. The undersigned has examined this application and certifies the information to be true and correct, and that in operating this business I agree to comply with all applicable laws and regulations relative thereto. I hereby grant the Town of Marion Board of Health and its designee permission to conduct unannounced inspections of my establishment at any time deemed appropriate by regulating authority. I acknowledge that if violations are found to exist at my establishment, I may be assessed penalties for violations which may include fines, suspension, or revocation of my license.

Pursuant to MGL c. 62 C, sec.49A, I certify under the penalties of perjury that the owner(s) of this establishment, to the best of my knowledge and belief, have filed all applicable tax returns and paid all taxes required under law. I, the undersigned, attest to the accuracy of the information provided in this application and affirm that this retail establishment will comply with Board of Health Tobacco Control Regulation Restricting the Sale of Tobacco Products and Nicotine Delivery Products and all other applicable laws. I have been instructed that a copy of the regulation is available at the Marion Health Department.

22) Signature of Applicant: _____

23) Social Security Number or Federal ID: _____

26) Signature of Individual or Corporate Name: _____

To be completed by the Board of Health

Total Permit Fee: _____
Payment is due with application