

PERMIT # \_\_\_\_\_ FEE \_\_\_\_\_ RECEIVED DATE \_\_\_\_\_ CHECK # \_\_\_\_\_



**Town of Granby**  
215B West State Street  
Granby, MA. 01033  
413-467-7174  
413-467-3101 Fax  
[boh@granbyma.org](mailto:boh@granbyma.org)

*Dear Licensee:*

**YOU MUST COMPLETE, SIGN AND PRESENT OR MAIL THIS FORM WITH YOUR REMITTANCE , A COMPLETED WORKMANS COMP FORM FOR THE STATE, AND A COPY OF YOUR LIABILITY INSURANCE, AND A COPY OF VICTUALLER’S LICENSE FROM SELECTMENTS OFFICE IN ORDER TO RECEIVE YOUR LICENSE/PERMITS.** The Board of Health office is located at 215B West State Street, Granby, MA. 01033, and our office hours are Monday – Friday 9:00 a.m. to 1:00 p.m.

Thank you,  
Granby Board of Health

Name of Business: \_\_\_\_\_  
(Print)

Phone: \_\_\_\_\_  
Cell: \_\_\_\_\_

Owners Name: \_\_\_\_\_  
(Print)

Mailing Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Business Address if different from mailing address: \_\_\_\_\_

**FID NUMBER:** \_\_\_\_\_

**MOTEL LICENSE.....\$50.00**

**\*ALL ANNUAL PERMITS EXPIRE DECEMBER 31.**

**\* PAYMENT IS DUE WITH THIS APPLICATION.**

Signature of Owner or Applicant and Title: \_\_\_\_\_

Date: \_\_\_\_\_

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