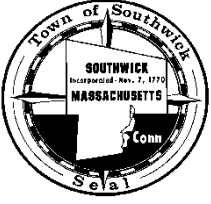


Date Received \_\_\_\_\_ Amount Paid \$ \_\_\_\_\_ Check # \_\_\_\_\_ Permit # \_\_\_\_\_  
FOR BOH OFFICE USE ONLY TCC: Initial \_\_\_\_\_ Date \_\_\_\_\_



**TOWN OF SOUTHWICK BOARD OF HEALTH**  
**FUNERAL DIRECTOR APPLICATION**  
**2024**

Southwick Board of Health  
454 College Highway  
Southwick, MA 01077  
(413) 569-1212

**Funeral Director Information**

Director's Name \_\_\_\_\_ Phone \_\_\_\_\_

Residential Address \_\_\_\_\_ Email \_\_\_\_\_

**Business Information**

Business Name \_\_\_\_\_

Business Address \_\_\_\_\_ Phone \_\_\_\_\_

Mailing Address \_\_\_\_\_ Email \_\_\_\_\_  
(if different)

**FILL OUT THE APPLICATION COMPLETELY AND SUBMIT THE APPROPRIATE CERTIFICATIONS AND FEES. INCOMPLETE APPLICATIONS WILL NOT BE CONSIDERED.**

**PLEASE SUBMIT THE COMPLETED APPLICATION WITH PAYMENT BY DECEMBER 1<sup>st</sup>. ANY DIRECTOR THAT HAS NOT SUBMITTED A RENEWAL APPLICATION BY DECEMBER 31<sup>st</sup>, WILL BE CONSIDERED OPERATING WITHOUT A PERMIT AND MAY BE ORDERED TO CEASE OPERATION UNTIL ALL THE PROPER PAPERWORK IS SUBMITTED.**

**APPLICATION FEE: \$ 100.00**

*I hereby certify that I am the funeral director and all the information provided is true. I agree to comply with the regulations set forth in M.G.L. c114. I agree to allow the Board of Health or its agents access to the establishment and to provide all required information. I agree to pay all appropriate fees at the time of application submittal.*

\_\_\_\_\_  
**SOCIAL SECURITY OR FEDERAL ID NUMBER**

\_\_\_\_\_  
**SIGNATURE OF DIRECTOR**

**CHECK OR MONEY ORDER**

**MAKE PAYABLE TO: Town of Southwick**

**NO REFUNDS**