

FOR OFFICE USE ONLY  
BTCP/REVENUE DEPT.

PAID BY:

Check # \_\_\_\_\_

Money Order # \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

BY: \_\_\_\_\_

**BOSTON  
PUBLIC  
HEALTH  
COMMISSION**



FOR OFFICE USE ONLY REVENUE DEPT.

**TOB-R-** \_\_\_\_\_

PAID BY:

Check # \_\_\_\_\_

Money Order # \_\_\_\_\_

DATE RECEIVED: \_\_\_\_\_

BY: \_\_\_\_\_

**This Application must be completed IN FULL and returned, along with a non-refundable fee (check or money order), the Owner/Operator Statement, and a copy of your Massachusetts State Department of Revenue Cigarette/Tob/Cigar Retailer's License( or other proof thereof), to BOSTON PUBLIC HEALTH COMMISSION, 1010 Massachusetts Ave., Boston, MA 02118, Attn: Revenue Dept/Tob. **INCOMPLETE APPLICATIONS WILL BE RETURNED WITHOUT THE NON-REFUNDABLE FEE.** For assistance, please call 617-534-4718.**

**Application Fees: A single \$300 fee for tobacco products including nicotine delivery products**

1. THIS APPLICATION IS FOR:  NEW PERMIT  RENEWAL OF PREVIOUS PERMIT# \_\_\_\_\_
2. RETAILER REQUEST TO SELL: A SINGLE \$300 FEE FOR TOBACCO PRODUCTS INCLUDING NICOTINE DELIVERY PRODUCTS
3. NAME OF RETAIL ESTABLISHMENT (as it appears on your City of Boston Business License):  
\_\_\_\_\_

4. ALTERNATE NAME OF ESTABLISHMENT (DBA) (other name under which the business operates):  
\_\_\_\_\_

5. LOCATION OF ESTABLISHMENT: \_\_\_\_\_ MAILING ADDRESS (if different from LOCATION): \_\_\_\_\_

Address Line 1

Address Line 1

Address Line 2

Address Line 2

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

6. HOURS OF OPERATION: \_\_\_\_\_ to \_\_\_\_\_ DAYS OF OPERATION: \_\_\_\_\_ thru \_\_\_\_\_

7. BUSINESS CATEGORY:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Grocery Store     | <input type="checkbox"/> Gas & Mini-Mart | <input type="checkbox"/> Gas Only               |
| <input type="checkbox"/> Convenience Store | <input type="checkbox"/> Liquor Store    | <input type="checkbox"/> Pharmacy               |
| <input type="checkbox"/> Restaurant        | <input type="checkbox"/> Bar/Tavern      | <input type="checkbox"/> Other (describe) _____ |

8. TYPE(S) OF SALES  Over the Counter  Vending Machine

9. NAME OF ESTABLISHMENT OWNER: \_\_\_\_\_

10. HOME PHONE: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

11. ARE YOU A NEW OWNER? Yes / No (Circle) IS THIS A SMOKING BAR or TOBACCONIST? Yes / No

12. NAME OF MANAGER (if different from Owner): \_\_\_\_\_

13. MA Department Of Revenue CIGARETTE RETAILER'S LICENSE NUMBER (CT-3T) \_\_\_\_\_

**(A copy of this license, or other proof of payment, MUST BE ATTACHED to this Application ;Retailers only selling Nicotine Delivery Products are not required to obtain a Department of Revenue License)**

**Pursuant to M.G.L. Chapter 62 C. Section 49A, I certify under the penalties of perjury that, to my best knowledge and belief, I have filed all state tax returns and paid all state taxes required under the law.**

Owner's Social Security # or Federal ID # \_\_\_\_\_

Signature of Applicant or Corporate Officer \_\_\_\_\_

Date \_\_\_\_\_