

Permit Number: _____

Fee: _____

COMMONWEALTH OF MASSACHUSETTS
TOWN OF NORTON
BOARD OF HEALTH

Application for Portable Sanitary Facility

Company Name: _____

Company Address: _____
St.# Street Town State Zip

Company Phone Number: _____

Contact Person: _____

Location of portable facility: _____

Approximate distance(s) from existing structures: _____

Number of Facilities: _____

Date facilities to be on site: _____

Date facilities to be removed: _____

Signature of Company official

***Effective October 29, 2007, the fee schedule is \$35.00 for the first 10 units per location and \$50.00 for 11 units or more per location.**