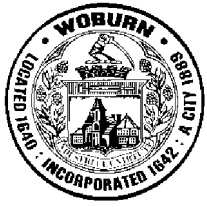


**PERMIT APPLICATION**



WOBURN BOARD OF HEALTH  
 10 Common Street  
 Woburn, MA 01801  
 781-897-5920  
 FAX: 781-897-5929

Est. Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_  
 Establishment Phone: \_\_\_\_\_

|   |  |
|---|--|
| <p><b>OWNER'S INFORMATION:</b></p> <p>Owner: _____</p> <p>Address: _____</p> <p>City, State, Zip: _____</p> <p>Phone: _____</p> <p>Email: _____</p> <p><b>ESTABLISHMENT INFORMATION:</b></p> <p>Hours of Operation: _____ If seasonal, date open: _____ date close: _____</p> <p>Certified Food Protection Manager(s): _____</p> <p>Person(s) Trained in Anti-Choking (required for food establishment with 25 seats or more): _____</p> <p><b>Tanning:</b> # of beds in establishment: _____</p> <p><b>Stables:</b> Type of animals: _____ # of animals: _____</p> <p>Name of Veterinary: _____ Phone: _____</p> <p>Address: _____</p> | <p><b>EMERGENCY CONTACT:</b></p> <p>Name: _____</p> <p>Title: _____</p> <p>24HR Emer. #: _____</p> <p>Email: _____</p> |
|---|--|

If Corporation or Partnership, please list Name, Title, & Home Address of Officers/ Partners: Attach if necessary.

| NAME: | TITLE: | ADDRESS: |
|-------|--------|----------|
| _____ | _____  | _____    |
| _____ | _____  | _____    |
| _____ | _____  | _____    |

| TYPE OF PERMIT:                                   | FEE:         | TYPE OF PERMIT:  | FEE:     |
|---|--------------|--|----------|
| <input type="checkbox"/> Supermarket              | \$ 100.00    | <input type="checkbox"/> Tanning   | \$ 50.00 |
| <input type="checkbox"/> Retail Food              | \$ 50.00     | <input type="checkbox"/> Stable  | \$ 25.00 |
| <input type="checkbox"/> Food Service             | \$ 50.00     | <input type="checkbox"/> Pool  | \$ 50.00 |
| <input type="checkbox"/> Elderly Care or Day Care | \$ 50.00     | <input type="checkbox"/> Spa   | \$ 50.00 |
| <input type="checkbox"/> Caterer                  | \$ 50.00     | <input type="checkbox"/> Wading Pool                                       | \$ 50.00 |
| <input type="checkbox"/> Church                   | \$ No Charge |  |          |
| Check if also using or selling:                   |              | Total Payment Due: \$ _____ (Make check payable to <b>City of Woburn</b> ) |          |
| <input type="checkbox"/> Milk, Cream, Ice Cream   | \$ 4.00      |  |          |
| <input type="checkbox"/> Tobacco                  | \$ 50.00     |  |          |

**I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the food establishment operation will comply with 105 CMR 590.000 and all other applicable laws. I certify under penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid state taxes required under law pursuant to MGL Ch. 62C, sec. 49A.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Print Name: \_\_\_\_\_ Social Security or FID#: \_\_\_\_\_

**\*PLEASE REMEMBER TO INCLUDE THE WORKER'S COMP FORM AND THE CERTIFICATION OF TREASURER AND COLLECTOR'S FORM.**

# CERTIFICATION OF TREASURER/COLLECTOR

(MGL c.40,§57; WMC 3-24)

Office Use Only: **DEPARTMENT**

**BOARD OF HEALTH**

**\*\* FAXES OR SIGNATURE COPIES WILL NOT BE ACCEPTED \*\***

**NOTE - ALL LINES MUST BE COMPLETED.** If any line is not applicable please write "N/A"

Property Address where permit is sought: \_\_\_\_\_  
Real Estate/Property Owner Name(s): \_\_\_\_\_  
Real Estate/Property Owner(s) Legal Business Name (if any): \_\_\_\_\_  
Real Estate Owner's Residential Address (if different): \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

Tenant/Lessee Legal Business  
Name: \_\_\_\_\_  
Business Owner Personal Name(s) (if any) \_\_\_\_\_  
Owner(s) Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

**Check one:**     Residential                       Individual/Sole Proprietor                       Corporation  
                   Trust     Other \_\_\_\_\_

**APPLICANT TO COMPLETE:**      **Failure to complete may result in delay of permit processing.**

\*Parcel which directly relates to the application filed for which certification is sought. (This numeric I.D. can be found: <http://data.visionappraisal.com/WoburnMA/>, on a tax bill, at the Building or Assessors offices).

(Example I.D.: 12-34-56)    Map \_\_\_\_\_    Block \_\_\_\_\_    Lot \_\_\_\_\_

**\*\*REQUIRED: Does Real Estate owner and/or tenant own or have a beneficial or financial interest in any other real estate properties within the city of Woburn?      Circle one:    NO    YES**

A beneficial interest can be as an individual, partnership, trust, LLP, etc. If YES, insert Map, Block, and Lot below for each property. Use back of form, if necessary.

Map \_\_\_\_\_    Block \_\_\_\_\_    Lot \_\_\_\_\_  
Map \_\_\_\_\_    Block \_\_\_\_\_    Lot \_\_\_\_\_

**I certify under the penalties of perjury that I am the record owner or tenant of the within described property and the above information is accurate and complete.**

\_\_\_\_\_  
Date    Signature of Applicant Property Owner or Tenant-- (Not contractor)

\_\_\_\_\_  
Title    Print Name

**(For Office Use Only)**

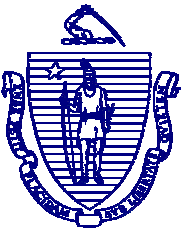
## CERTIFICATION OF TREASURER/COLLECTOR

The records of this office indicate that there are no unpaid real estate taxes, municipal fees, liens or other municipal charges outstanding and unpaid, or for the payment of which the owner has entered into a payment agreement with this office, on the above described parcels as of:

\_\_\_\_\_  
Certification Date

EXPIRES: \_\_\_\_\_  
(Residential Only)

\_\_\_\_\_  
Treasurer/Collector



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 600 Washington Street  
 Boston, MA 02111  
 www.mass.gov/dia

**Workers' Compensation Insurance Affidavit: General Businesses**

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- 1.  I am a employer with \_\_\_\_\_ employees (full and/ or part-time).\*
- 2.  I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
- 3.  We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]\*\*
- 4.  We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

**Business Type (required):**

- 5.  Retail
- 6.  Restaurant/Bar/Eating Establishment
- 7.  Office and/or Sales (incl. real estate, auto, etc.)
- 8.  Non-profit
- 9.  Entertainment
- 10.  Manufacturing
- 11.  Health Care
- 12.  Other \_\_\_\_\_

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

\*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

**I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.**

Insurance Company Name: \_\_\_\_\_

Insurer's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy # or Self-ins. Lic. # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).**

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

**I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.**

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

Phone #: \_\_\_\_\_

*Official use only. Do not write in this area, to be completed by city or town official.*

City or Town: \_\_\_\_\_ Permit/License # \_\_\_\_\_

**Issuing Authority (circle one):**

- 1. Board of Health
- 2. Building Department
- 3. City/Town Clerk
- 4. Licensing Board
- 5. Selectmen's Office
- 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

# Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an *employee* is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An *employer* is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

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## Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

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## City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

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The Department's address, telephone and fax number:

The Commonwealth of Massachusetts  
Department of Industrial Accidents  
**Office of Investigations**  
600 Washington Street  
Boston, MA 02111

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

[www.mass.gov/dia](http://www.mass.gov/dia)