



WOBURN BOARD OF HEALTH
10 Common Street
Woburn, MA 01801
781-932-4407



Vehicle/Pushcart Name _____

Make, Model & Year of Vehicle _____

State of Registration _____ Registration/Plate # _____ State Hawkers License # _____

Owner Name _____

Owner Address _____
Street City State & Zip

Email Address _____

Business Phone No _____ Home Phone No _____

Base of Operation _____
Name phone number

_____ Street City State & Zip

Permits Needed

<u>Permits Needed</u>	<u>Fee</u>
Mobile Food	\$50.00
Milk, Cream, Ice Cream	\$ 4.00
Tobacco	\$50.00

Total Payment Due With Application: \$ _____

CERTIFIED FOOD PROTECTION MANAGER: Have certificate on site _____

Location of offsite restroom facilities _____

Time and location where food is sold _____

<u>Food Products Sold</u>	<u>Source of Food Products</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that the mobile food 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 Federal I.D. Number _____



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 an 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 #: _____

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 - ~~APPLICANT MUST BE COMPLETE~~. 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 tenants 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