

**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>EMERGENCY CONTACT:</b></p> <p>Name: _____</p> <p>Title: _____</p> <p>24HR Emer. #: _____</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>Tanning: # of beds in establishment: _____</p> <p>Stables: Type of animals: _____ #of animals: _____</p> <p style="margin-left: 40px;">Name of Veterinary: _____ Phone: _____</p> <p style="margin-left: 40px;">Address: _____</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 City of Woburn)	
<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 - ~~THIS FORM IS NOT TO 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 #: \_\_\_\_\_