West Bridgewater Board of Health
65 North Main Street
West Bridgewater, Ma 02379
508-894-1209 fax 508-894-1214
Email dgreen@Wbridgewater.com

Mass.Gov. Department of Revenue Reporting Form

ESTABLISHMENT NAME_____

PRINT ONLY

License Yr. 2014

Identification: (*circle one***)**
Type FEIN-SSN-ITIN
ID#_____

License
Type _____
Number *******

New Renewal

ServSafe Person_____

Hydraulic#_____

Expiration (Date of above)_____

Address 1_____
Address 2_____
City _____
State _____
Zip _____
Phone _____

Mailing Address (*Provide Alternate if using business address above***.)**

Address 1_____
Address 2_____
City_____
State_____
Zip_____
Country_____
Phone_____

Business Information

Legal Name_____
DBA_____
Owners Last Name_____
Owners First Name_____
Owners Middle Name_____
Org Type_____

Hours of Operation _____
_____

DOT # _____

Seating Capacity _____

You must complete **ALL** information requested on this sheet. This information is what will be reported to DOR. You must sign below stating that you acknowledge this, and the information above is true.

Signature Date

_____
PRINT NAME

Please note that all information on this form is requested. Missing information will deem this form incomplete and your permit will be delayed. Delayed permits will be subject to fines.

Your Certificate of Workers Comp. and Liability Insurance must be attached.

I Certify under the penalties of perjury that I to my best knowledge and belief, have filed all state taxes under law.

_____ _____

Signature of individual or Corporate Name (Mandatory)

By: Corporate Officer

_____ _____

Social Security # Or Federal Identification Number

Printed Name

This license will not be issued unless this certification clause is signed by the applicant.

Your social security number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligation.
Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request if made under the authority of Mass G.L.c62Cs.

Received _____ 20
AM_____

_____
Signature of Applicant

Hour_____
PM_____

_____
Address

Approved _____20____

License Granted_____20_____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
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: **Business Type (required)**:

☐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.]
☐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:_____