Whitman Board of Health

54 South Avenue
P.O. Box 426
Whitman, MA 02382
(781)618-9755 Fax (781)-618-9798

Application for Rubbish/Debris Removal Permit
Including construction dumpsters (1 application per company)

Date: _____ **Cost: $ 250.00**

The undersigned hereby applies for a License/Permit in accordance with the provisions of the Statutes relating thereto

Name: _____

Business address: _____

Mailing address: _____

Business telephone: _____ **Emergency telephone:** _____

In the Town of Whitman in accordance with the rules and regulations made under authority of said Statutes.

Requirements:

- **Regular trash pickup -Please attach a list of clients in Whitman (Please note: client list is not required for construction dumpsters unless available at time of application)**
- **Worker's Compensation Insurance Affidavit**
- **Certificate of Liability Insurance**

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that this operation will comply with all applicable laws and regulation.

I certify under penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

_____ _____

Signature of Individual or Corporate Name **Corporate Officer's Signature**

_____

Federal Identification Number

Office Use:

Date received: _____ License Number: _____

Date approved: _____ Check Number: _____ Check Date: _____

Board of Health
Town of Whitman
54 South Avenue, P.O. Box 426
Whitman, Massachusetts 02382-0426

TAXES PAID AFFIDAVIT

Date: _____

Type of license applying for: _____

Business name: _____

Business address: _____

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes as required under law. As of the above date, all bills for this property/business are current in the Whitman Collector's office.

_____ _____

*Signature of Individual by: Corporate Officer

_____

**Social Security Number Voluntary
Or Federal Identification Number

*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 obligations. Licensees who fail to correct their non-filing or delinquency **will be subject to license suspension or revocation. This request is made under the authority of M.G.L. Chapter 62C, Section 49A.

Updated 10/16

Telephone: 781-618-9754 Facsimile 781-618-9798 e-mail health@whitman-ma.gov

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 #:** _____