

# Whitman Board of Health

54 South Avenue

P.O. Box 426

Whitman, MA 02382

(781)618-9755 Fax (781)-618-9798

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## 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

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## 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

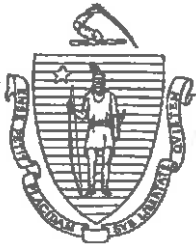
\_\_\_\_\_  
by: Corporate Officer

\_\_\_\_\_  
\*\*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



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