TOWN OF AQUINNAH

BOARD OF HEALTH

955 State Road, Aquinnah, Massachusetts 02535
(508) 645-2309 - Fax (508) 645-7884 - E-Mail: healthagent@aquinnah-ma.gov

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Application for Disposal Works Installer's Permit

Permit #:_____

Permit Fee $100.00 (checks made out to Town of Aquinnah) paid:_____

Permit expires at the end of the calendar year in which it is issued unless sooner revoked for cause.

Company:_____

Contact Person:_____

Mailing Address:_____

_____

Phone# Office:_____ Cell:_____

Fax:_____ E-mail:_____

The undersigned hereby agrees to comply with the Town of Aquinnah Board of Health Regulations and relevant provisions of the Massachusetts State Environmental Code: Title 5, 310 CMR 15.00.

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

Signature of Applicant:_____

Date:_____

Board of Health Approval:_____

Approval Date:_____

Please submit with the workers compensation insurance affidavit and attach a copy of the workers compensation policy declaration page (showing policy number and expiration date).

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Septic Installer Installation Compliance

Date:_____

Company:_____

Property Owner:_____

Address:_____

_____

Map:_____Lot:_____

Date of installation:_____

I,_____(Installer), certify that the septic system was installed as per the Aquinnah Board of Health approved design plan and all changes were reported to the Board of Health in the As-Built Plans.

Signature of Licensed Installer:_____

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

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 #:**_____