HAMILTON BOARD OF HEALTH
577 Bay Road, P.O. Box 429
Hamilton, MA 01936

Tel: 978-468-5579 **Fax: 978-468-5582**

APPLICATION FOR SEPTAGE HAULER PERMIT

The Septage Hauler's Permit expires annually on December 31. **The fee for the license renewal is $200.00**. Please fill out this application and submit to the Board of Health office with a check payable to the "Town of Hamilton". **Certificate of Liability Insurance and Workers Compensation Insurance Affidavit is required with application.**

In accordance with M.G.L. c. 111, Section 31B and 310 CMR 15.402 (Title 5) the undersigned makes application to the Board of Health for permission to remove and transport septage and the content of privies and cesspools as set forth below:

Name of Applicant:_____

Business Name:_____

Address: _____

Telephone Number: _____Email_____

List below: Type of Equipment, Gallon Capacity, and Date of Vehicle Inspection: (add additional pages if needed)

_____

_____

_____

List areas where septage will be accepted from (and append customer list):

_____

_____

List all locations where septage will be disposed (include a copy of the contract or the approval for use of the disposal location):

_____

_____

I certify that the information I have provided above is true and accurate. I recognize that it is a violation of this permit to dispose of septage anywhere other than the identified disposal locations or others approved of the Board in writing as an amendment to this permit. Note: Local regulation adopted January 2015 states septage haulers must file a pumping report with the Board of Health within 14 days of pumping activity.

Date _____ Signature of Applicant_____

For Office Use Only

✓Certificate of Liability Insurance Received _____
✓Workers Compensation Insurance Affidavit Received _____

Permit #_____ Date Issued: _____

TOWN OF HAMILTON

To the Hamilton Board of Health:

In accordance with the provisions of the Statutes relating thereto, application for a Permit is hereby made by:

Name:_____

Address:_____

Work Phone:_____ Email_____

For: Pumping and Transportation of Septage

Type of Truck	Year	Model	Registration Number

_____
(Signature of Applicant)

Pursuant to M.G.L. Ch. 62C, sec. 49A,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 required under laws.

_____
Signature of Individual or Corporate Name

_____
Social Security Number or FIN

by_____
Corporate Officer (if applicable)

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 #:**_____