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

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

APPLICATION FOR DISPOSAL SYSTEM INSTALLER'S LICENSE
to Construct, Alter, Install, or Repair Sewage Disposal Systems

The Disposal System Installer's License expires annually on December 31. Please fill out this application and return to the Board of Health office with a check payable to the Town of Hamilton.

In the accordance with the provisions of the State Environmental Code, Title 5, 310 CMR 15.019, the undersigned makes application to the Hamilton Board of Health for a Disposal System Installer's License.

Renewal ___________ Fee $150.00 **New _____________ Fee $250.00 (non-refundable)**

Name of Applicant:____

Business Name:____

Street Address:____

Mailing Address:____
(if different)

City:_______________________________ State__________ Zip Code__________

Email:____

Business Phone:_______________________ Cell Phone:_______________________

Date:____________________ Signature of Applicant:_______________________________

<u>All Applications Require</u>:
Certificate of Liability Insurance
Workers Compensation Insurance Affidavit

<u>and for New Applicants</u>
3 signed letters of recommendation from <u>professionals</u>* familiar with the Applicant's work (include phone numbers)
*Professionals include: Septic Installers, Septic Designers, Health Agents
and
Copies of Installer's licenses with other Boards of Health

<u>New</u> applications received by April 1, August 1, and December 1 will be reviewed by the end of that month.

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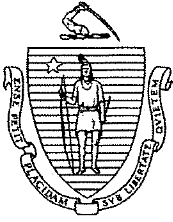
For Office Use Only

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

Permit #______________ Date Issued: _______________

Application updated June 2019



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 #:**____________________