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 PERMIT
to Construct, alter, install, or repair Individual Sewage Disposal Systems

The Disposal System Installer's Permit expires annually on December 31. **The fee for license renewal is $150.00.** 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, application for a Disposal System Installer's Permit is hereby made by

_____
Name (Full name of individual & firm or corporation making application)

_____
Firm Address

_____ _____
Phone E-Mail

_____ _____
(Signature of Applicant) Date

_____
Home Address

Renewal _____ New _____

Applications Require:
Certificate of Liability Insurance
Workers Compensation Insurance Affidavit

and for New Applicants
3 signed letters of references from professionals* 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

Pursuant to M.G.L. Ch. 62C, sec. 49A, I certify under the penalties of perjury that I, to my knowledge and belief, have filed all state tax returns and paid all state taxes require under law.

_____ _____
Social Security Number or Federal Identification Number
Signature of Individual or Corporate Name

by: _____
Corporate Officer (if applicable)

For Office Use Only

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

Permit #_____ Date Issued: _____

Application updated 2/13/18

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 #:**_____