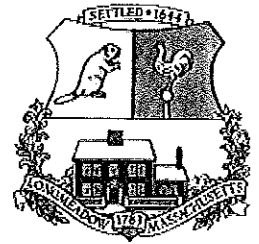
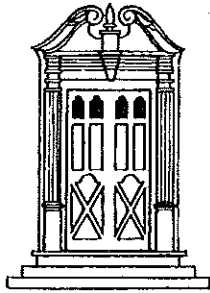


FEE \$ 165.00



town of
LONGMEADOW, MASSACHUSETTS

phone: (413) 565-4140 20 Williams Street 01106

BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

BOARD OF HEALTH

- MICHAEL COPPOLA, M.D.
- BARRY IZENSTEIN, M.D.
- ROBERT RAPPAPORT, D.M.D.
- RICHARD STEINGART, M.D.
- MARY P. TOYE, R.N., M.S.

Application for Septage Hauler Permit

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: _____ Fax Number: _____

List registration numbers of Vehicles and their gallonage capacity:

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

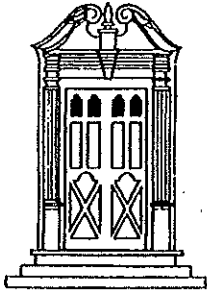
CERTIFICATIONS:

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 in writing by Board as an amendment to this permit.

I further certify that the equipment used for septage pumping and hauling conforms with 310 CMR 15.505 transfer of septage from one tanker truck to another is prohibited within the Town of Longmeadow (15.504).

Finally, I will provide the Longmeadow Board of Health with a "System Pumping Record" on the DEP approved form within 14 days of each system pumping performed in the Town of Longmeadow.

Date _____ Signature of Applicant _____



town of
LONGMEADOW, MASSACHUSETTS

phone: (413) 565-4140 20 Williams Street 01106



BOARD OF HEALTH

MICHAEL COPPOLA, M.D.

BARRY IZENSTEIN, M.D.

ROBERT RAPPAPORT, D.M.D.

RICHARD STEINGART, M.D.

MARY P. TOYE, R.N., M.S.

BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

**MANDATORY CERTIFICATION FOR APPLICANTS
FOR BOARD OF HEALTH LICENSES**

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 law.

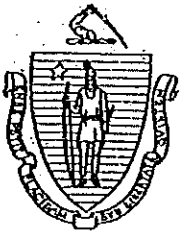
Signature of Individual or Corporate Name
(Mandatory)

By: Corporate Office Mandatory, if Applicable

Social Security or Federal Identification Number
(Voluntary)

Your license(s) 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 Mass G.L.C. 62C. S.49A.



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 an 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: LONGMEADOW 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: BEVERLY S. HIRSCHORN Phone #: (413) 565-4140