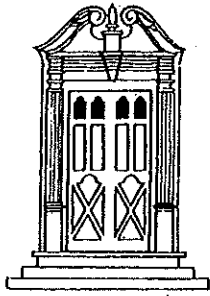


FEE: \$400.00



town of
LONGMEADOW, MASSACHUSETTS

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

BEVERLY S. HIRSCHHORN, CHO, MPH
Health Director

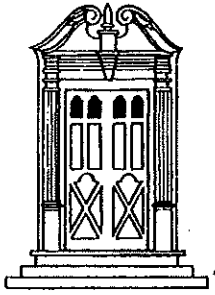
BOARD OF HEALTH
MICHAEL COPPOLA, M.D.
BARRY IZENSTEIN, M.D.
ROBERT RAPPAPORT, D.M.D.
RICHARD STEINGART, M.D.
MARY P. TOYE, R.N., M.S.

APPLICATION FOR LICENSE TO OPERATE A HEALTH CLUB

1. Full name of applicant _____
(Name of Business)
2. Business Address _____
3. Telephone Number _____
4. If applicant is sole owner, full name and address

5. If applicant is partnership, full name and address of all partners

6. Is applicant a corporation _____ State of Incorporation _____
Full name and address of:
President _____
Treasurer _____
Clerk _____
Signature of person preparing application _____ Date _____
Home address _____



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LONGMEADOW, MASSACHUSETTS

phone: (413) 565-4140

20 Williams Street

01106



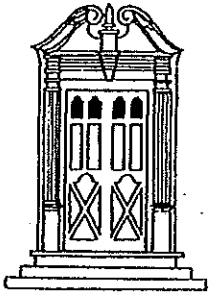
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OPERATING CONDITIONS FOR HEALTH CLUB

1. Telephone required. Posting of 911 Sign adjacent to the telephone(s)
2. Water fountain or bottled water available
3. First Aid Kit
4. Provide copy of sign off sheet for minors to be signed by parent or guardian to Board of Health
5. Provide copy of a medical screening questionnaire to Board of Health
6. Restroom must be equipped with toilet/sink/soap/paper towels and covered trash receptacle
7. TB testing of employees; provide Board of Health with documentation
8. Physical facilities: clean
9. Equipment shall be safe for use (e.g. no sharp edges); all surfaces which have direct contact with users must be "easily cleanable"



For Businesses Only



town of
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**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

For Businesses Only

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 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: LONGHEAD W 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: DEVERLY S. HIRSCHHORN Phone #: (413) 565-4140