Town of East Bridgewater
Board of Health
175 Central Street | East Bridgewater MA 02333
PH: (508) 378-1612 [Email: healthpermits@eastbridgewaterma.gov

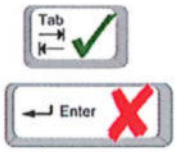
APPLICATION FOR SEPTIC HAULER PERMIT
(Permits Expire Yearly on December 31st)

_____
COMPANY NAME

Please attach this page with your completed application

- ☐ Certificate of Insurance for Liability
- ☐ Certificate of Insurance for Workers' Compensation
- ☐ **Copy of Disposal Site Authorization from the Town where sewerage is being disposed in *(Must Be Attached)***
- ☐ Non-Refundable Fee of $100 (Check made payable to the Town of East Bridgewater)

IMPORTANT: When filling out Forms on the computer, use TAB key to move to next line – DO NOT USE the ENTER key.



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" PLEASE NOTE THAT SIGNATURES ARE REQUIRED ON PAGES **

Applicants may either mail their information or apply in person at the Board of Health office.

The office hours are Monday 8:30am - 8pm Tuesday thru Thursday from 8:30am - 4:30pm and Friday 8:30 - Noon.

BOARD OF HEALTH OFFICE USE ONLY

APPLICATION APPROVED: ☐ YES ☐ NO

NOTES: _____

_____

_____

_____ _____
DATE BOARD APPROVED

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APPLICATION FOR SEPTIC HAULER PERMIT

(Permits Expire Yearly on December 31st)

FEE: $100

permit #: _____

In accordance with M. G. L. c. 111, Section 31 B and 310 CMR 15.000 (Title V) the undersigned makes application to the Board of Health for permission to remove and transport septage and the contents of privies and cesspools as set forth below:

Company Name _____ Owner/Applicant Name _____

Company's Physical Address _____ City _____ State _____ Zip _____

Company's Mailing Address *(If Different from Above)* _____ City _____ State _____ ZIP _____

Office Phone Number _____ Cell Phone Number _____

Name of Person Responsible for Daily Operations _____ Phone Number _____

Email Address _____

PLEASE CHECK ALL THAT APPLIES: ☐ Portable Toilets ☐ Pumping of Septic Systems

VEHCILE INFORMATION THAT WILL BE USED IN THE TOWN OF EAST BRIDGEWATER
(Attach Additional Sheets If Necessary)

VEHICLE REGISTRATION #:	LICENSE PLATE #:	TYPE OF EQUIPMENT	CAPACITY OF TRUCK

CERTIFICATION:

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 location or other approved of the Board in writing as an amendment to this permit.

Signature of Owner/Applicant _____ Date _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
Lafayette City Center
2 Avenue de Lafayette, Boston, MA 02111-1750
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 and 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 § 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: ☐ Board of Health ☐ Building Dept. ☐ City/Town Clerk ☐ Licensing Board ☐ Selectmen's Office ☐ Other: _____

Contact Person: _____ **Phone #:** _____