



TOWN OF STERLING

BOARD OF HEALTH

Butterick Municipal Building

One Park Street, Sterling, MA 01564

978-422-8111 X2305 * Fax 978-422-0289

DISPOSAL WORKS INSTALLER'S LICENSE APPLICATION

Attached please find an application for renewing your disposal works installer's license from the Sterling Board of Health. If you intend to install or repair septic systems in Sterling, please provide the following:

- Completed Application
- Fee of \$75.00
- Completed Workers' Compensation Insurance Affidavit
- Certificate of Insurance for Workman's Comp and Liability
- Completed R.E.A.P. form
- Two references from other Towns in which you hold licenses
(Required if a Sterling license not held the previous year)
- Completion, with passing grade of 90%, of an Installer's exam to be scheduled with the Sterling Board of Health Agent prior to the issuance of permit.....fee \$50.00. This only applies to installers who haven't taken the exam before 2007.

Note the Department of Industrial Accidents, pursuant to MGL, Chapter 152, Sec 25A, requires both the affidavit and certificate of insurance to be on file in the town in which the installer is doing business.

The provision of 310 CMR 15.021 (3), Title V requires that the system installer submit a signed certificate of compliance to the Board of Health for every septic system installed. Receipt of this form will be required before the Board of Health's final certificate of compliance will be issued.

Kathleen Nickerson
Associate Health Agent

kln 12/12

THE COMMONWEALTH OF MASSACHUSETTS

TOWN OF STERLING

**APPLICATION FOR LICENSE
To INSTALL AND/OR REPAIR SEPTIC SYSTEMS**

NUMBER _____

DATE _____

TO THE LICENSING AUTHORITIES:

In accordance with the provisions of the Statutes relating thereto, the State Environmental Code, 310 CMR 15.000, and Sterling's Subsurface Disposal System Regulations, an application for a license is hereby made by:

NAME: _____
(Full name of person making application)

(Address....Number, Street, State, Zip Code)

LICENSE ISSUED _____

(Signature of applicant)

(Mailing Address if different than above)

(Telephone)

(Cell)

(Email)

By signing this application, the installer is acknowledging that as a condition of receiving the license, the holder agrees to comply with all State and Local Code requirements. Furthermore, failure to comply with applicable State and Local regulations is cause for revocation of the license by the local approving authority issuing said license. Be aware that the Installer's License is issued to an individual and not a company. If the individual leaves the company, the new individual from the company needs to apply to the Sterling Board of Health for a license in their name which involves another application along with the necessary paperwork, including the septic installer's test.

Everything must be completed on the application before a license will be issued. If you have any questions, please call.....978-422-8111 X2305.

R.E.A.P. FORM

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.

_____ by: _____

**Signature of Individual/Corporate
Name (mandatory)**

**Corporate Officer
(mandatory if applicable)**

Social Security # (voluntary) or Federal Identification #

This license 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. 62C s47A

Name of Business/Organization

Name of Individual



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 1 Congress Street, Suite 100
 Boston, MA 02114-2017
 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 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 #: _____

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an **employee** is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An **employer** is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749 www.mass.gov/dia