APPLICATION FOR PERMIT FOR THE REMOVAL AND TRANSPORTATION OF SEPTIC TANK WASTE WITHIN THE NASHOBA DISTRICT

In accordance with the State Sanitary Code, Title 5, Regulation 310 CMR 15.502, the undersigned makes application to the Board of Health, for the member communities, for a permit to remove and transport the contents of privies, cesspools, septic tank, and other offensive substances as specified under Regulation 15.502.

NAME OF APPLICANT __________________________________________________

BUSINESS NAME ___________________________________________ BUSINESS PHONE ________________

ADDRESS ___________________________________________ Town _________________________________

LOCATION OF APPROVED DISPOSAL FACILITY ________________________________

NUMBER OF PIECES OF EQUIPMENT _______ Email ____________________________________________

License plate #’s _____ _____ _____ _____

The Nashoba Associated Boards of Health (NABH), acting as agents for our member Boards of Health, will make all inspections and issue this permit. It will be the responsibility of the applicant to make arrangements with the NABH for an inspection of the equipment used for pumping and hauling of sewage.

Please include with your completed application a payment for the sum of one-hundred & fifty ($225.00) dollars, payable to the Nashoba Associated Boards of Health.

In accordance with 310 CMR 15.502 (3&4) *This application must be accompanied by the following documentation.

1.) A copy of your agreement/approval for your disposal location (treatment facility).
2.) Proof that you have registered with, or are a licensed septage hauler by the Board of Health of the community in which you dispose of your septage.

Pursuant to M.G.L. CH. 62C, SEC. 49A 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. I CERTIFY THAT I HAVE WORKERS COMPENSATION COVERAGE AS REQUIRED BY LAW (complete enclosed form).

_________________________ ____________________
SOCIAL SECURITY # OR OWNER FEDERAL ID #

_________________________ ____________________
SIGNATURE OF INDIVIDUAL OR CORPORATE NAME DATE

*There is a 15% processing charge on all refunds.

Enc. Rev 7/1/20

(978) 772-3335  (800) 427-9762  FAX (978) 772-4947
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 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(d), 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):

☐ Retail

☐ Restaurant/Bar/Eating Establishment

☐ Office and/or Sales (incl. real estate, auto, etc.)

☐ Non-profit

☐ Entertainment

☐ Manufacturing

☐ Health Care

☐ 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 #2.

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):


6. Other ________

Contact Person: ____________________________ Phone #: _____________

www.mass.gov/dia