Town of Carlisle
Office of
BOARD OF HEALTH
66 Westford Street
Carlisle, MA 01741

Tel.: (978) 369-0283
Fax: (978) 369-4521
Boardofhealth@carlislema.gov

APPLICATION FOR SEPTAGE HAULER PERMIT 2024

In accordance with MGL c. 111, Section 31B and 310 CMR 15.502 (Title 5), the undersigned makes an 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			
COMPANY			
ADDRESS			
CITY/TOWN		**STATE**	**ZIP**
TELEPHONE		**EMAIL**	

Pumping records shall be submitted to the Approving Authority within 14 days from the pumping date in accordance with 310 CMR 13.351(1).

List below the number and types of equipment and their gallon capacity:

_____

_____

_____

List all locations where Septage will be disposed of including a copy of the contract or the approval for use of the disposal location.

_____

_____

_____

FEE: $200.00
(Payable to *Town of Carlisle* and non-refundable)
PERMIT WILL EXPIRE DECEMBER 31, 2024

APPLICATION FOR SEPTAGE HAULER PERMIT 2024 continued

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 others approved by the Board in writing as an amendment to this permit.

I further certify that pursuant to MGL C. 62C s. 49A that to the best of my knowledge and belief, I have filed all state tax returns and paid all states required under law.

_____

Signature of Individual or Corporate Officer

_____

Date

_____

Social Security Number (voluntary)[1] or Federal Identification Number

[1]Note: Your Social Security number may be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing payment obligations

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: Builders/Contractors/Electricians/Plumbers

Applicant Information **Please Print Legibly**

Name (Business/Organization/Individual): _____

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 partner-ship and have no employees working for me in any capacity. [No workers' comp. insurance required.]
3. ☐ I am a homeowner doing all work myself. [No workers' comp. insurance required.] †
4. ☐ I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have employees and have workers' comp. insurance.‡
5. ☐ We are a corporation and its officers have exercised their right of exemption per MGL c. 152, §1(4), and we have no employees. [No workers' comp. insurance required.]

Type of project (required):

6. ☐ New construction
7. ☐ Remodeling
8. ☐ Demolition
9. ☐ Building addition
10. ☐ Electrical repairs or additions
11. ☐ Plumbing repairs or additions
12. ☐ Roof repairs
13. ☐ Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.
† Homeowners who submit this affidavit indicating they are doing all work and then hire outside contractors must submit a new affidavit indicating such.
‡Contractors that check this box must attached an additional sheet showing the name of the sub-contractors and state whether or not those entities have employees. If the sub-contractors have employees, they must provide their workers' comp. policy number.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy and job site information.

Insurance Company Name: _____

Policy # or Self-ins. Lic. #: _____ Expiration Date: _____

Job Site Address: _____ City/State/Zip: _____

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 (check one):
1☐Board of Health 2☐Building Department 3☐City/Town Clerk 4.☐Electrical Inspector 5☐Plumbing Inspector 6.☐Other _____

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