



Nashoba Associated Boards of Health
Environmental Health Service
30 Central Avenue, Ayer, Ma. 01432

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 **\$225.00**, 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 8/9/22

(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(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 #: _____