



## TOWN OF SOUTHAMPTON

### BOARD OF HEALTH

210 College Highway – Suite 4  
Southampton, MA 01073  
Office (413) 529-1003  
Fax (413) 529-6847  
boardofhealth@townofsouthampton.org

#### TRASH HAULER PERMIT APPLICATION

**Fee: \$200.00 PER Truck**

Date: \_\_\_\_\_

Company Name: \_\_\_\_\_

Contact Person: \_\_\_\_\_

Street: \_\_\_\_\_ Town/City: \_\_\_\_\_

Zip Code: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax: \_\_\_\_\_ Email: \_\_\_\_\_

<u>Vehicle Type</u>	<u>Capacity</u>	<u>Plate #</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Year's company has been in business: \_\_\_\_\_

Transfer Facility used for dumping: \_\_\_\_\_

City/Town: \_\_\_\_\_ Phone #: \_\_\_\_\_

Transfer Station Permit #: \_\_\_\_\_

Please fill out attached Worker's Compensation Insurance Affidavit

Worker's Compensation Insurance Affidavit Attached: Yes  No

The undersigned hereby agrees to comply with all the Laws, Rules, and Regulations of the Commonwealth of Massachusetts and the Town of Southampton and Southampton Board of Health Rules and Regulations governing the removal, transport, and disposal of refuse and recyclable materials; and is aware that failure to comply with said laws, rules, and regulations could result in suspension or revocation of permits herewith applied for. Any substantial changes must be immediately reported to the Health Department.

Signature of Owner or Company Official

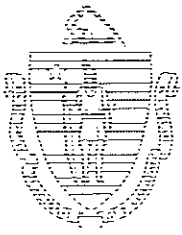
Social Security # or Federal ID #

\_\_\_\_\_

\_\_\_\_\_

Print Name and Title

\_\_\_\_\_



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 600 Washington Street  
 Boston, MA 02111  
 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 #: \_\_\_\_\_