

***Town of Marshfield
Board of Health
870 Moraine Street
Marshfield, MA 02050
781-834-5558
fax 781-837-6047***

***INSTALLER'S LICENSE RENEWAL APPLICATION -
\$150.00***

PLEASE PRINT

Company Name: _____

Owner's Name: _____

Email Address: _____

Mailing Address: _____

Business Address: _____
(if different than mailing)

Business Phone: _____ Home Phone _____

Cell Phone : _____ Fax # _____

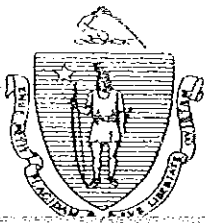
Please read and sign this statement:

"I have read and am familiar with the Town of Marshfield Rules and Regulations for the disposal of sanitary sewage, as well as the Title V State regulations for sewage disposal."

Signature _____

Date _____

Please complete attached worker's compensation form



The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street, 7th Floor; Boston, Mass. 02111
Workers' Compensation Insurance Affidavit

Applicant information:

Please PRINT legibly

name: _____

location: _____

city: _____

phone # _____

☐ I am a homeowner performing all work myself.

☐ I am a sole proprietor and have no one working in any capacity

☐ I am an employer providing workers' compensation for my employees working on this job.

company name: _____

address: _____

city: _____

phone #: _____

insurance co. _____

policy # _____

☐ I am a sole proprietor, general contractor, or homeowner (circle one) and have hired the contractors listed below who have the following workers' compensation policies:

company name: _____

address: _____

city: _____

phone #: _____

insurance co. _____

policy # _____

company name: _____

address: _____

city: _____

phone #: _____

insurance co. _____

policy # _____

Attach additional sheet if necessary

Failure to secure coverage as required under Section 25A of MGL 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one years' imprisonment as well as civil penalties in the form of a STOP WORK ORDER and a fine of \$100.00 a day against me. I understand that a copy of this statement may be forwarded to the Office of Investigations of the DIA for coverage verification. I do hereby certify under the pains and penalties of perjury that the information provided above is true and correct.

Signature _____

Date _____

Print name _____

Phone # _____

official use only do not write in this area to be completed by city or town official

city or town: _____ permit/license # _____

☐ check if immediate response is required

contact person: _____ phone #: _____

☐ Building Department

☐ Licensing Board

☐ Selectmen's Office

☐ Health Department

☐ Other _____