

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

***INSTALLER'S LICENSE APPLICATION***

PLEASE PRINT

**Fee: \$150.00**

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

Owner's Name: \_\_\_\_\_

Installers Name: \_\_\_\_\_

Email Address: \_\_\_\_\_

Business Address: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Cell Phone/Business Phone: \_\_\_\_\_

**REFERENCES: (NOT NECESSARY ON RENEWALS)**

New Installers please attach copies of 3 current Installer's Licenses from other towns and list below.

Town(s) 1) \_\_\_\_\_  
2) \_\_\_\_\_  
3) \_\_\_\_\_

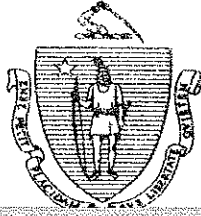
**Please read and sign this statement:**

"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, 7<sup>th</sup> 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