



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 LICENSE 2023

In accordance with MGL c. 111, Section 31B and 310 CMR 15.502 (Title 5), the undersigned makes application to the Board of Health for permission to remove and transport septage and the content of privies and cesspools as set forth below:

<b>NAME</b>			
<b>COMPANY</b>			
<b>ADDRESS</b>			
<b>CITY/TOWN</b>		<b>STATE</b>	<b>ZIP</b>
<b>TELEPHONE</b>	<b>EMAIL</b>		

**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 number and types of equipment and their gallon capacity:

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

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<p style="text-align: center;"><b>FEE: \$200.00</b> (Payable to Town of Carlisle and non-refundable) <b>PERMIT WILL EXPIRE DECEMBER 31, 2023</b></p>
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**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.

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**Signature of Individual or Corporate Officer**

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**Date**

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**Social Security Number (voluntary)<sup>1</sup> or Federal Identification Number**

<sup>1</sup>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  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Print Form

**Workers' Compensation Insurance Affidavit: Builders/Contractors/Electricians/Plumbers**  
**Applicant Information** **Please Print Legibly**

Name (Business/Organization/Individual): \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

<p><b>Are you an employer? Check the appropriate box:</b></p> <p>1. <input type="checkbox"/> I am an employer with _____ employees (full and/or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required.]</p> <p>3. <input type="checkbox"/> I am a homeowner doing all work myself. [No workers' comp. insurance required.] †</p> <p>4. <input type="checkbox"/> 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. ‡</p> <p>5. <input type="checkbox"/> 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.]</p>	<p><b>Type of project (required):</b></p> <p>6. <input type="checkbox"/> New construction</p> <p>7. <input type="checkbox"/> Remodeling</p> <p>8. <input type="checkbox"/> Demolition</p> <p>9. <input type="checkbox"/> Building addition</p> <p>10. <input type="checkbox"/> Electrical repairs or additions</p> <p>11. <input type="checkbox"/> Plumbing repairs or additions</p> <p>12. <input type="checkbox"/> Roof repairs</p> <p>13. <input type="checkbox"/> Other _____</p>
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\*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 (circle one):  
 1. Board of Health 2. Building Department 3. City/Town Clerk 4. Electrical Inspector 5. Plumbing Inspector  
 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_