



TOWN OF CARLISLE

Office of the Board of Health

66 Westford St. Carlisle MA 01741 (978) 369-0283 boardofhealth@carlislema.gov

SEPTIC INSTALLER PERMIT APPLICATION 2026

FEE \$200/\$250 PAID []

In accordance with 310 CMR 15.019 (Title 5) the undersigned hereby applies for a permit to install septic disposal systems in the Town of Carlisle. A renewal permit will be issued if the applicant has satisfactorily performed septic installation work in the town within the previous 24 months. All other applicants must pass a written examination to be qualified. Septic Installer Permits shall be valid for the calendar year, expiring on December 31st of each year, renewable annually.

Please submit your completed application with the appropriate fee(s) and required documents.

Fees, Exam and Payment

- Conventional Septic Disposal System installations: \$200
- I/A technology installations: additional \$50
- Installer Exam: \$75. Required for applicants who have not performed septic installation work in Carlisle within the last 24 months.
- Checks payable to "Town of Carlisle", non-refundable.

Required Forms/Certificates

- Workers' Compensation Insurance Affidavit (see page 2)
- Certificate of Liability Insurance
- Proof of I/A technology certification

Name _____

Company _____

Mailing Address _____

City/Town _____ State _____ Zip _____

Phone _____ Email _____

Applicant Signature _____ Date _____

Tax Certification

I 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.

Individual/Corporate Officer Signature _____ Date _____

Social Security Number (voluntary)¹ or Federal Identification Number _____

¹Your 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
 Lafayette City Center
 2 Avenue de Lafayette, Boston, MA 02111-1750
 www.mass.gov/dia

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

Name (Business/Organization/Individual): _____

Address: _____

City/State/Zip: _____ Phone #: _____

<p>Are you an employer? Check the appropriate box:</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>Type of project (required):</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 (check one):	
1 <input type="checkbox"/> Board of Health 2 <input type="checkbox"/> Building Department 3 <input type="checkbox"/> City/Town Clerk 4 <input type="checkbox"/> Electrical Inspector 5 <input type="checkbox"/> Plumbing Inspector 6 <input type="checkbox"/> Other _____	
Contact Person: _____	Phone #: _____