



TOWN OF CARLISLE

**Office of the Board of Health**

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

**TITLE 5 INSPECTOR PERMIT APPLICATION 2026**

**FEE \$25 PAID [ ]**

In accordance with M.G.L. c.111, Section 1, and Carlisle’s Title 5 Supplementary Regulations, the undersigned makes an application to the Carlisle Board of Health for permission to conduct official Title Inspections within the Town of Carlisle.

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

**Fee and Payment**

[ ] \$25.00 fee (Check payable to the “Town of Carlisle”, non-refundable)

**Required Documents**

- [ ] Workers’ Compensation Insurance Affidavit (see page 2)
- [ ] Certificate of Liability Insurance
- [ ] Copy of your DEP-Approved Title 5 Septic System Inspector Card

**Name of Title 5 Inspector** \_\_\_\_\_

**Name of Owner/Corporation Name** \_\_\_\_\_

**Mailing Address** \_\_\_\_\_

**City/Town** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

**Phone** \_\_\_\_\_ **Email** \_\_\_\_\_

Pursuant to M.G.L. Ch. 62C, Sec. 49A, I certify under the pains and penalties of perjury, that I, to the best of my knowledge and belief, have filed all state tax returns and paid state taxes required under law.

I certify the information I have provided above is true and accurate. I agree to comply with Title 5 regulations and any rules, regulations or policies of the Town of Carlisle. I agree to conduct thorough and complete inspections, including ground water investigations, and to submit complete and accurate inspection reports. I understand that failure to do so may result in suspension of the Carlisle Title 5 Inspector Permit.

**Signature of Title 5 Inspector** \_\_\_\_\_ **Date** \_\_\_\_\_



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><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 #: \_\_\_\_\_

<b>Official use only. Do not write in this area, to be completed by city or town official.</b>	
City or Town: _____	Permit/License # _____
<b>Issuing Authority (check one):</b>	
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 #: _____