



**CITY OF FRAMINGHAM**  
Public Health Department



**Public Health**  
Prevent. Promote. Protect.

(508) 532-5470  
health@framinghamma.gov  
www.framinghamma.gov

**MEMORIAL BUILDING**  
150 Concord Street, Room 205  
Framingham, MA 01702

**Disposal System Installer Permit Application**

Complete the following application. Please print legibly. Incomplete applications may delay the permitting process.

According to 310 CMR 15.019 no individual shall engage in the construction, upgrade, modification, emergency repair, or expansion of any on-site system without first obtaining a Disposal System Installer's Permit from the Approval Authority.

Date: \_\_\_\_\_

**Type of Application**

New

Renewal

Include copies of three (3) current installer licenses from other Massachusetts communities.

**Business/Firm Information**

Name of Company/Firm: \_\_\_\_\_

Address: \_\_\_\_\_ Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Owner Information**

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

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Licensed Installer Information**

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

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact Information**

Name of Emergency Contact Person: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Statement: Pursuant to M.G.L. Ch. 62C, Sec. 49A, I \_\_\_\_\_ certify under the pains and penalties for perjury that I, to the best knowledge and belief, have filed all state tax returns and paid all state taxes required under law. I hereby certify that I have read and fully understand the subsurface sewage disposal systems as required by the provisions of the State Environmental Code, Title V, and the rules and regulations of the Framingham Board of Health.

Signature: \_\_\_\_\_ Print: \_\_\_\_\_

Federal Tax ID: \_\_\_\_\_

**To obtain a Disposal System Installer Permit, submit the following:**

- Completed "Application for a Disposal System Installer Permit". **Incomplete applications and missing documents may delay the permitting process.**
- Permit Fee - **\$100.00** – Make check payable to the "**City of Framingham**". **All fees are nonrefundable.**
- Completed "Workers' Compensation Insurance Affidavit: General Businesses". Attach a copy of the workers' compensation policy declaration page that shows the policy number and expiration date.
- Include copies of three (3) current installer licenses from other Massachusetts communities if this is a **NEW** application.

**Note: The Installer's Permit is issued to an Individual and NOT a Company**

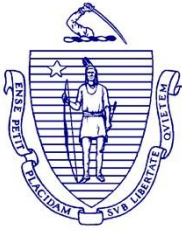
**For Official Use Only**

- Approved as submitted**
- Approved as submitted with the following conditions:** \_\_\_\_\_
- Disapproved as submitted – Reason(s): \*\*** \_\_\_\_\_

**\*\* Applicant can resubmit an updated application or provide additional information to address the reason(s) why the application was disapproved.**

Date Reviewed: \_\_\_\_\_ Reviewed By: \_\_\_\_\_ Public Health Inspector

Date Permit was Issued: \_\_\_\_\_



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.  
 TO BE FILED WITH THE PERMITTING AUTHORITY.

**Applicant Information**

**Please Print Legibly**

Business/Organization Name: \_\_\_\_\_

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"/> We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p><b>Business Type (required):</b></p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Eating Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
---	--

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

\*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

**I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.**

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

Insurer's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy # or Self-ins. Lic. # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**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. Licensing Board 5. Selectmen's Office

6. Other \_\_\_\_\_

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

# Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an *employee* is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An *employer* is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "**every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required.**" Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

---

---

## Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. **Also be sure to sign and date the affidavit.** The affidavit should be returned to the city or town that the application for the permit or license is being requested, **not** the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

---

---

## City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

---

---

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts  
Department of Industrial Accidents  
1 Congress Street  
Boston, MA 02114-2017  
Tel. # 617-727-4900 ext. 7406 or 1-877-MASSAFE  
Fax # 617-727-7749  
[www.mass.gov/dia](http://www.mass.gov/dia)