



Town of Orleans

Health Department

19 School Road ~ Orleans, MA 02653-3699

T: 508-240-3700
Ext. 450

F: 508-240-3746

2009

Attached is your 2009 Application.

ALL FORMS MUST BE FILLED OUT COMPLETELY.

Fees must be paid by **CHECK ONLY**, no cash will be accepted.

Included in your packet:

- 2009 Application
- Town of Orleans/Health Dept. (pink form) for Outstanding Property Taxes, Personal Property Taxes and Unpaid Water Bills
- Massachusetts Department of Revenue (REAP) Tax Form
- Workers' Compensation Insurance Affidavit (required by the Commonwealth of Massachusetts, Dept. of Industrial Accidents, Office of Investigations)

Call the Health Department @ 508-240-3700, x450, if you have any questions.

THANK YOU,
The Orleans Health Department

FEE: \$75.00

(Plus sticker if disposing refuse at Orleans Facility)

TOWN OF ORLEANS – BOARD OF HEALTH
APPLICATION FOR REFUSE COLLECTION AND TRANSPORTATION
2009

PLEASE ANSWER ALL QUESTIONS:

Name of Business: _____

Mailing Address: _____

Business Address: _____

Business Telephone/FAX _____

Owner's Name: _____

Owner's Address: _____

Owner's Telephone: _____

Number of Rubbish Trucks:

List each truck by Load Capacity and Registration Number:

- | | | |
|----|-------|----------------------|
| 1. | _____ | Registration # _____ |
| 2. | _____ | Registration # _____ |
| 3. | _____ | Registration # _____ |
| 4. | _____ | Registration # _____ |
| 5. | _____ | Registration # _____ |
| 6. | _____ | Registration # _____ |

() NEW () RENEWAL

Have you had a Refuse Collection and Transportation Permit in Orleans or any other Cape Cod town revoked or suspended in the past five years?

SIGNATURE _____ DATE _____

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT and PROTECTION (REAP) ATTESTATION

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

* **Signature of Individual or Corporate Name (Mandatory)**

By: Corporate Officer (Mandatory, if applicable)

** **Social Security No. (Voluntary) or Federal Identification Number**

* This license will not be issued unless this certification clause is signed by the Applicant.

** Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations.

Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. GL c. 62C s. 49A.

Town of Orleans - Health Department

IMPORTANT - PLEASE READ

In accordance with Chapter 64 Fees, Chapter V *Nonpayment of Fees and Taxes* § 94-6 *Grant or Renewal of License or Permit as Affected by Nonpayment of Local Taxes or Fees* of the Code of the Town of Orleans, you are hereby notified that renewal of your license(s) may be denied if there are any real estate and/or personal property taxes, water bills, betterments, assessments or other municipal charges more than twelve (12) months past due. This includes money owed to the Town by your landlord if you lease the property where your business is located.

If you are unable to get the signature of the Tax Collector on this notification or to negotiate a payment plan with the Tax Collector, you are entitled to a hearing before the Board/s. At the hearing you or your designee will be allowed to present evidence as to why your license should be renewed.

APPLICANT'S NAME: _____

D/B/A, IF APPLICABLE: _____

BUSINESS OWNER'S NAME: _____

BUSINESS ADDRESS: _____

If you lease property, list property owner please:

Outstanding Property Tax Outstanding Personal Property Tax Outstanding Water Bill

The above named applicant has applied to the Town of Orleans for a permit or license. We find the applicant to be current on all municipal charges pursuant to Chapter 94, Section 6. We find the property owner to be current on all municipal taxes, assessments, betterments and other municipal charges pursuant to Chapter 94, Section 6.

Date: _____ Tax Collector's Office: _____

Non-Taxpayers to the Town of Orleans ... AND/OR ... Non-Profits:

I certify that we are a Non-Profit organization and do not pay any taxes to the Town of Orleans.

Date

Signature of Applicant



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: _____

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"/> 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>Business Type (required):</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>
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*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 #: _____

<p><i>Official use only. Do not write in this area, to be completed by city or town official.</i></p>	
City or Town: _____	Permit/License # _____
<p>Issuing Authority (circle one):</p> <p>1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office</p> <p>6. Other _____</p>	
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 Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia