

TOWN OF WARE – BOARD OF HEALTH
MASSACHUSETTS 01082

2009 License/Permit Renewal Application

Date _____

Name of Establishment _____

Telephone # _____

Business Address _____

Mailing Address _____

Person in Charge _____

Telephone # _____

Name of Owner _____

Telephone # _____

Address of Owner _____

<u>Permit Type</u>	<u>Permit Fee</u>
<input type="checkbox"/> Retail	\$125.00 / \$600.00
<input type="checkbox"/> Food Service	\$150.00
<input type="checkbox"/> Limited / Type II	\$ 25.00
<input type="checkbox"/> Residential Kitchen	\$ 50.00
<input type="checkbox"/> Catering	\$100.00
<input type="checkbox"/> Bakery	\$150.00
<input type="checkbox"/> Milk & Cream	\$ 15.00
<input type="checkbox"/> Frozen Desserts	\$ 25.00
<input type="checkbox"/> Tobacco	\$100.00
<input type="checkbox"/> Motel / Trailer Park	\$150.00
<input type="checkbox"/> Tanning	\$ 75.00
<input type="checkbox"/> Tattoo Artist	\$ 50.00
<input type="checkbox"/> Tattoo Facility / Parlor	\$150.00

TOTAL DUE - \$ _____ Make check payable to: Town of Ware

Are you an Employer? Check appropriate box:

- I am an employer with ___ employees(full/part time)*
- I am a sole proprietor or partnership and have no employees
- We are a Corporation and it's officers have exercised their right or exemption per c.152,s1(4), and we have no employees
- We are a non-profit organization, staffed by volunteers, with no employees

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 worker's compensation policy declaration page (showing policy # 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 pains and penalties of perjury that the information provided above is true and correct.

SIGNATURE _____

DATE _____

PRINT NAME _____

PHONE # _____

OFFICE USE: FEE COLLECTED \$ _____ DATE FEE COLLECTED _____
PERMIT # ISSUED _____