Town of Shutesbury
P.O. Box 276
Shutesbury, MA 01072
(413) 259-1214
Fax (413) 259-1107
E-mail townadmin@shutesbury.org

Permit Number_____
Date Issued_____
Expiration Date_____
Fee: NONE

TRENCH PERMIT

Pursuant to G.L. c. 82A §1 and 520 CMR 7.00 et seq.(as amended)

THIS PERMIT MUST BE FULLY COMPLETED PRIOR TO CONSIDERATION

Name of Applicant **Street Address**			**Phone**	**Cell**
City/Town	**MA**	**ZIP**		
Name of Excavator (if different from applicant) **Street Address**			**Phone**	**Cell**
City/Town	**MA**	**ZIP**		
Name of Owner(s) of Property **Street Address**			**Phone**	**Cell**
City/Town	**MA**	**ZIP**		
Other Contact			**Permit Fee Received No ( ) Yes ( )**	
Description, location and purpose of proposed trench: **Please describe the exact location of the proposed trench and its purpose (include a description of what is (or is intended) to be laid in proposed trench (eg; pipes/cable lines etc..) Please use reverse side if additional space is needed.**				
Insurance Certificate #:				
Name and Contact Information of Insurer:				
Policy Expiration Date:				
Dig Safe #:				
Name of Competent Person (as defined by 520 CMR 7.02):				

Submit your completed application by dropping it off at Town Hall OR by mailing it to Shutesbury Highway Department, 59 Leverett Rd, Shutesbury, MA 01072.

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 #:_____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ employees (full and/ or part-time).*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. ☐ 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]**
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other _____

*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 #:**_____

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 # (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-filng or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.**