Office of
Board of Health

Town of Marshfield
Board of Health
870 Moraine Street
Marshfield, Massachusetts, 02050
Tel: 781-834-5558 Fax: 781-837-6047

Monthly pumping records are required.

SEPTAGE HAULER APPLICATION

PLEASE submit: Completed application, Worker's Compensation Form & fee

Fee: $125.00 per truck

Company Name : _____

Contact Person_____

Owner :_____

Business Address :_____

_____

Mailing Address (if different)_____

Business Phone: _____Fax:_____

Email Address: _____Cell Phone :_____

List **all** pumping vehicles with Year, Make, Vehicle ID and Gallonage Capacity:

1._____
2._____
3._____

Date of Vehicle Inspection: _____

List all locations where septage will be disposed of (include a copy of the contract or written approval for use of such disposal location):

NOTE: INTERCOMMUNITY DISPOSAL.....The contents of any vehicle licensed herein may be disposed of in a sanitary manner in any other city or town subject to the written approval of the MARSHFIELD BOARD OF HEALTH and the written approval of the Authority having control of the disposal site.
{Title 5, 15.19 (51)}

I certify that the information I have provided above is true and accurate. I recognize that it is a violation of this permit to dispose of septage anywhere other than the identified disposal locations or others approved of by the Board as an amendment to this permit.

I hereby acknowledge that all of the above information is true and that I, as an individual or corporation, do not owe the Town of Marshfield any outstanding property taxes and / or other assessments.

Date_____Signature of Applicant _____

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street, 7th Floor; Boston, Mass. 02111

Workers' Compensation Insurance Affidavit

Applicant information: **Please PRINT legibly**

name: _____

location: _____

city _____ phone # _____

☐ I am a homeowner performing all work myself.

☐ I am a sole proprietor and have no one working in any capacity

☐ I am an employer providing workers' compensation for my employees working on this job.

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

☐ I am a sole proprietor, **general contractor**, or **homeowner** (*circle one*) and have hired the contractors listed below who have the following workers' compensation polices:

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

Attach additional sheet if necessary

Failure to secure coverage as required under Section 25A of MGL 152 can lead to the imposition of criminal penalties of a fine up to $1,500.00 and/or one years' imprisonment as well as civil penalties in the form of a STOP WORK ORDER and a fine of $100.00 a day against me. I understand that a copy of this statement may be forwarded to the Office of Investigations of the DIA for coverage verification. ***I do hereby certify under the pains and penalties of perjury that the information provided above is true and correct.***

Signature _____ Date _____

Print name _____ Phone # _____

official use only do not write in this area to be completed by city or town official

city or town: _____ **permit/license #** _____

☐ **Building Department**
☐ **Licensing Board**
☐ **Selectmen's Office**
☐ **Health Department**
☐ **Other** _____

☐ **check if immediate response is required**

contact person: _____ **phone #:** _____

(revised 9/95 PJA)