IMPORTANT

Dear License Holder:

It is time to renew the license issued by the Somerville Board of Aldermen. We are converting to a new software system, and you will see below the information we have on file for your license. Please fill out all six boxes below with the correct information so we can update our records, and return all of the pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

License Type: Extended Operating Hours
License Number: #191176
Business Name: Cataldo Ambulance Service
Location: 137 Washington St
Special Conditions (if any): Su-Sa, 24 Hrs,

Renewal Fee (Return with this application): $550

PLEASE FILL IN ALL SIX BOXES BELOW:

2012 MAY -3 P 6:12
CITY CLERK'S OFFICE
SOMERVILLE, MA

The DBA Name of the Business: ______
Somerville Address and Zip Code: ______
Phone Number of the Business: ______

The Legal Name of the License Holder: Cataldo Ambylance Service, Inc.
Street Address of the License Holder: 137 WASHINGTON STREET
City, State and Zip Code of the License Holder: SOMERVILLE, MA 02143
Phone Number of the License Holder: 617-625-0126
Email Address of the License Holder: ______

Where We Should Send Mail: Name: CATALDO AMBULANCE SERVICE, INC.
Street Address: 137 WASHINGTON STREET
City, State and Zip Code: SOMERVILLE, MA 02143
Email: ______
Phone Number: 617-625-0126

Federal ID # (Do Not Give a Social Security #): 04-2621862

Emergency Contact and Phone (For Fire Dept. Use): ______

-OVER-

1 check for extended hours & Garage. 5-3-2012
CK 0099801
$550 -

Type of Business (Check Only One and Give the Names Indicated):

___Sole Proprietor: Name of Owner:__________

___Partnership (inc. LLP): Names of All Partners Who Own More Than 10%:__________

___Trust: Names of All Trustees Who Own More Than 10%:__________

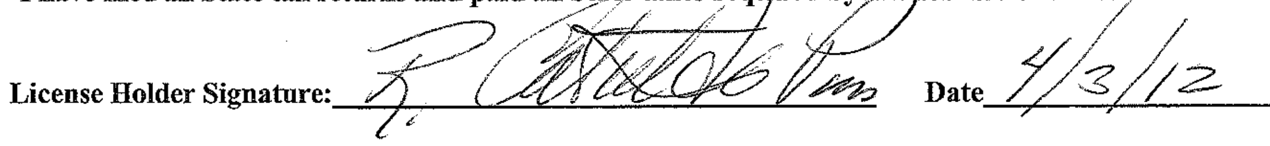
__X_Corporation (inc. LLC): Name of President: ROBERT D. CATALDO

Name of Secretary: DIANA M. CATALDO

Name of Treasurer: DIANA M. CATALDO

___Other (Attach a Description of the Form of Ownership and the Names of Owners)

ACKNOWLEDGEMENT: I hereby certify under the penalties of perjury that the following is true:
-All information shown above is true and accurate.
-Any changes above are subject to the approval of the Somerville Board of Aldermen.
-I have filed all State tax returns and paid all State taxes required by law for this business.



License Holder Signature: __________ **Date** 4/3/12

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: CATALDO AMBULANCE SERVICE, INC.

Address of taxpayer/applicant's business in Somerville: 137 WASHINGTON STREET

Address of taxpayer/applicant's home in Somerville: ______

Taxpayer/applicant's phone: day: 617-625-0126 evening: ______

I, (print name) ROBERT D. CATALDO, the undersigned Taxpayer, do hereby certify that all the information contained herein is true and correct and all taxes and fees due the City have been paid or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

SIGNED UNDER THE PAINS AND PENALTIES OF PERJURY, this 3rd day of APRIL, 20 12. R. Cataldo Pres.
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: ______ **INCLUDES RELEVANT POSTINGS THROUGH:** ______

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate ☐ Water/Sewer ☐ Personal Property ☐ Other: ___

03113130 # 145017011 # 1318 # ______

NOTES: 15467

CLERK'S INITIALS: LB **ORIGINAL STAMP:**

RECEIVED
5-13-18

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

Workers' Compensation Insurance Affidavit - General Business

Applicant information:

Name: CATALDO AMBULANCE SERVICE, INC.

Address: 137 WASHINGTON STREET

City: SOMERVILLE State: MA Zip: 02143 Phone #: 617-625-0126

- [x] I am an employer with 600 employees (full and/or part time).
- [ ] I am a sole proprietor or partnership and have no employees.
- [ ] We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees.
- [ ] We are a nonprofit organization staffed by volunteers and have no employees.

Business Type:

- [ ] Retail
- [ ] Restaurant/Bar/Eating Establishment
- [ ] Office and/or Sales (real estate, auto, etc.)
- [ ] Nonprofit
- [ ] Entertainment
- [ ] Manufacturing
- [ ] Health Care
- [ ] Other

Workers' compensation insurance information (if applicable):

Insurance Company Name: CRUM & FORESTER/HUB INTERNATIONAL

Address: 299 BALLARDVALE STREET

City: WILMINGTON State: MA Zip: 01887 Phone #: 978-657-5100

Policy #: WCA 0354329 - 11 Expiration Date: 09/19/12

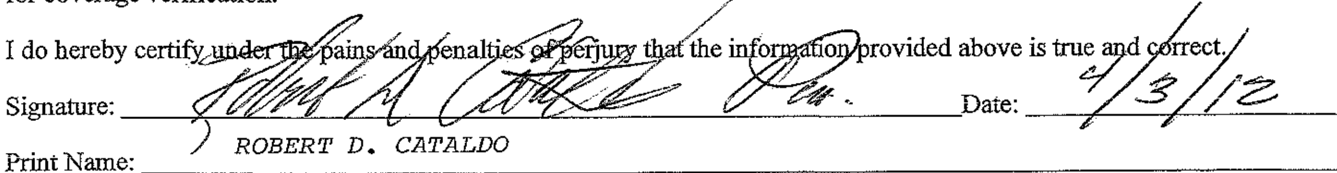
Applicant certification:

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: [signature] Pres. Date: 4/3/12

Print Name: ROBERT D. CATALDO



Official use only. Do not write in this area. To be completed by city or town official.

City or Town: ________ *Permit/License #:* ________

Contact Person: ________ *Phone #:* ________

- [ ] *Board of Health*
- [ ] *Building Department*
- [ ] *City/Town Clerk*
- [ ] *Licensing Board*
- [ ] *Selectmen's Office*
- [ ] *Other* ________

(revised Jan. 2008)