



**CITY OF SOMERVILLE
BOARD OF ALDERMEN**
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143
(617) 625-6600

CR 12605
550.00

2013 APR 17 P 2:14

APPLICATION TO RENEW GARAGE LICENSE

CITY CLERK'S OFFICE
SOMERVILLE, MA

CBRE
65 LANDSDOWNE ST
CAMBRIDGE, MA 02139

License #: 945

Fee: 550.00

Account ID: 749

Reference #: 945

Review and update the information below. If you have workers compensation insurance, attach proof showing the insurer and policy number. Then sign the Acknowledgment and return this form with your fee to the City Clerk's Office.

INFORMATION ON FILE:	CHANGES: (Note below or explain on a separate sheet)
Business/DBA Name: For PARTNERS HEALTHCARE SYSTEM INC.	
Business Location: 21 THIRD AVE	
Business Phone: 617-278-1037	
License Holder: PARTNERS HEALTHCARE SYSTEM INC. 21 THIRD AVE SOMERVILLE, MA 02143 617-278-1037	
Mailing Address: CBRE CAMBRIDGE, MA 02139	
Business Type: CORPORATION (INC. LLC) PRESIDENT - GARY GOTTLIEB SECRETARY - MAUREEN GOGGIN	
FID: 043230035	
Food Manager/Emergency Contact: REBECCA COBURN 617-726-5400	

Conditions: (to change any conditions, submit a new application. Contact the City Clerk's Office for more information)

Hours: **MO-FR 4AM-MIDNITE, SA 8AM-7PM**

NOT OPEN TO THE PUBLIC

1 MECHANICAL REPAIRS	76 VEHICLES INSIDE
1 STORING VEHICLES	93 VEHICLES OUTSIDE
169 VEHICLES	1 WASHING VEHICLES

Description of Location and/or Other Conditions:

Approved 5/10/12. Amended 5/24/12. No Auto Body. No Spray Painting. No Operating Tow Vehicles.

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 BOARD OF ALDERMEN.

-I have filed all State tax returns and paid all State taxes required by law for this business.

Signature: KATHRYN WEST

Date: 3/18/13

Print Name: KATHRYN WEST

Phone: 617-724-5223

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: Partners HealthCare System, Inc.
Address: Prudential Center, 800 Boylston Street, 11th Floor
City: Boston State: MA Zip: 02199 Phone #: 617-278-1037

- ☒ I am an employer with 60,000 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 (non-profit)
☐ Other

Workers' compensation insurance information (if applicable):

Insurance Company Name: Self-Insured; see attached DIA certificate
Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____
Policy #: See attached DIA certificate Expiration Date: _____

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: Kate West Date: 3/18/13
Print Name: KATHERYN WEST

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 #: _____

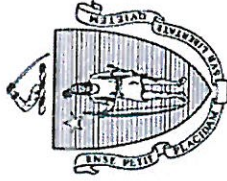
☐ Board of Health
☐ Building Department
☐ City/Town Clerk
☐ Licensing Board
☐ Selectmen's Office
☐ Other

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

License No.
873

Serial No.
11616



This is to Certify that PARTNERS HEALTHCARE SYSTEM, INC. AND ITS' SUBSIDIARIES
of 101 Merrimac St., Boston, MA 02114, having conformed with the provisions of
sub-paragraph (2, b) of Section 25A of Chapter 152 of the General Laws is hereby licensed
to be a

SELF-INSURER

This license is effective for a period of one year from the F I R S T day of
S E P T E M B E R 20 12 at 12:01 A.M., unless sooner revoked.

DEPARTMENT OF INDUSTRIAL ACCIDENTS

A handwritten signature in blue ink, appearing to read "Charles F. Halloran", written over a horizontal line.

D I R E C T O R

THIS LICENSE MUST BE POSTED AT THE LOCATION OF THE BUSINESS



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Partners Healthcare System, Inc.

Address of taxpayer/applicant's business in Somerville: 21 Third Avenue Somerville, MA 02143

Address of taxpayer/applicant's home in Somerville: N.A.

Taxpayer/applicant's phone: day: 617-278-1037 evening: 617-278-1037

I, (print name) Kathryn West, Vice President of Real Estate + Facilities, 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 18th day of March, 2013. Kathryn West
(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: _____

14747 # 551001042 # 249 # _____

NOTES:

CLERK'S INITIALS: UBS

ORIGINAL STAMP: 

RECEIVED
UBS
4-17-13