$500

NOTE: COMPLETE FORM AND FOWARD WITH FEE TO CITY CLERK' OFFICE.
DO NOT RETURN FORM TO DEPARTMENT OF PUBLIC SAFTY.

THE COMMONWEALTH OF MASSACHUSETTS

2011 APR 28 P 4:18

DEPARTMENT OF PUBLIC SAFETY - DIVISION OF FIRE PREVENTION
1010 COMMONWEALTH AVE. BOSTON

CITY CLERK'S OFFICE
SOMERVILLE, MA

RENEWAL APPLICATION FOR STORAGE OF FLAMMABLES LICENSE

In accordance with the provisions of Chapter 148, Section 13, of the General Laws, the undersigned hereby certifies that:
SOMERVILLE HOSPITAL
230 HIGHLAND AVE, ATTN: M. LETZEISEN/PLANT OPE.
SOMERVILLE MA 02143 4444

Lic#: F-2011-220
B.O.A.#: 168379
Fee: $500.00

Restricted to: 15,000 Gallons Total
Restricted as follows;
Gallons of #2 fuel oil. Subject to Fire Dept. and ISD Inspection and 30 days plan being furnished to the city

Is the holder of the license originally granted 02/15/2001
for the lawful use of the building (s) or other structure (s) situated or to be situated at 00230 HIGHLAND AV
as related to the KEEPING, STORAGE, MANUFACTURE, OR SALE OF FLAMMABLES OR EXPLOSIVES. City of Somerville.
Note: This Certificate of Registration must be signed by the holder of the license if said license was granted prior to July 1, 1936, otherwise by the owner or occupant of the land licensed.

____ KINDLY CORRECT ANY ERRORS LISTED ON OUR CURRENT RECORDS ABOVE, ____
AND COMPLETE THE LOWER SECTION OF THIS RENEWAL APPLICATION.

Company Name: SOMERVILLE HOSPITAL TEL: 617-591-4337
Company Address: 00230 HIGHLAND AV
City: SOMERVILLE State: MA Zip: 02143

Check One:
Individual: ___ Co: X Corp: ___ Trust: ___ Agency ___ Gov't Ship ___ Partner ___ Other

Owner Name: SOMERVILLE HOSPITAL TEL: ____
Owner Address: 230 HIGHLAND AVE, ATTN: M. LETZEISEN/PLANT OPE.
Owner City: SOMERVILLE State: MA Zip: 02143
FID#: 042103852

This Application must be signed and filed with the required fee no later than April 30, 2011. The responsibility for filing on time is yours.
If the renewal application is not returned to the City Clerk's office by 04/30/2011 please advise this office at once.
This renewal application must be signed by the holder of the license.
Check One: Owner ____ Occupant ____ Holder X

Dennis D. Keeke
Signature of Applicant

230 Highland Avenue
Address

Somerville, MA 02143
City State Zip

** Office Use Only **
Mailed ____
Taken ____

Received: ____

City Clerk

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

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.

Somerville Hospital

* Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

04-2103852

** Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

* 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-filing 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.

City of Somerville, Massachusetts
Finance Department, Treasury Division

WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Somerville Hospital

Address of taxpayer/applicant's business in Somerville: 230 Highland Avenue

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

Taxpayer/applicant's phone: day: 617-591-4425 evening: _____

I, (print name) Dennis Keefe, as President/CEO, 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 6th day of April, 20 11. Dennis D. Keefe
(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: ___
# 2003870	# 66107000	#	#
	66107001		
	66107002		
	66107003		
	66107004		

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** received 4-28-11

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

Workers' Compensation Insurance Affidavit - General Businesses

Applicant Information Please PRINT legibly

name: Somerville Hospital (Cambridge Health Alliance)

address: 1493 Cambridge Street

city Cambridge state: MA zip: 02139 phone # 617-665-1000

work site location (full address): 230 Highland Avenue, Somerville, MA 02143

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

Business Type: ☐ Retail ☐ Restaurant/Bar/Eating Establishment ☐ Office ☐ Sales (including Real Estate, Autos etc.)

☐ I am an employer with 350 employees (full & part time). ☒ Other Health Care

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

company name: Cambridge Health Alliance

address: 1493 Cambridge Street

city: Cambridge phone #: 617-665-1000

insurance co: Sentry Insurance policy # 90-15402-04

☐ I am a sole proprietor and have hired the independent 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 Dennis D. Keefe Date 4/6/11

Print name Dennis Keefe, President/CEO Phone # 617-665-1000

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 Sept. 2003)