



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

2013 JAN -8 A 8:51

**APPLICATION TO RENEW OUTDOOR SEATING LICENSE**CITY CLERK'S OFFICE  
SOMERVILLE, MA 02143  
License #: 1018

**AMETHYST CHIROPRACTIC, PC**  
259 ELM ST  
SUITE 300  
SOMERVILLE, MA 02144

Fee: 150.00  
Account ID: 792  
Reference #: 1018

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 <b>AMETHYST CHIROPRACTIC, PC</b> Business Location: <b>259 ELM ST</b> Business Phone: <b>617-591-9200</b>	
License Holder: <b>AMETHYST CHIROPRACTIC, PC</b> <b>259 ELM ST</b> <b>SUITE 300</b> <b>SOMERVILLE, MA 02144</b> <b>617-591-9200</b>	
Mailing Address: <b>AMETHYST CHIROPRACTIC, PC</b> <b>SUITE 300</b> <b>SOMERVILLE, MA 02144</b>	
Business Type: <b>CORPORATION (INC. LLC)</b> <b>PRESIDENT - LINDA SQUIRES</b> <b>SECRETARY - LINDA SQUIRES</b>	
FID: <b>043305477</b>	
Food Manager/Emergency Contact: <b>LINDA SQUIRES</b>	

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

Hours: **MO-SU 5-10PM SEATS/9PM GOODS**

**1 A-FRAME SIGNS**

Description of Location and/or Other Conditions:

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:  Date 01/07/2013

Print Name: Linda S. Squires, D.C. Phone 617-591-9200

## IMPORTANT

It's time to renew your Outdoor Seating and Goods license. We are converting to new software, and the enclosed page shows the information we have on file for your license. Please fill out that page AND the 6 boxes below with the correct information. **Return all 4 pages with your fee and with evidence that 1) your \$5,000 Licenses and Permits Bond remains in effect, OR 2) your business liability insurance lists the City as an Additional Insured. Call John Long, City Clerk, at 617 625-6600 x4110 if you have any questions.**

The DBA Name of the Business: Amethyst Chiropractic, P.C.  
Somerville Address and Zip Code: 259 Elm St., Ste 300 Somerville, MA 02144  
Phone Number of the Business: 617-591-9200

The Legal Name of the License Holder: Linda S. Squires  
Street Address of the License Holder: 259 Elm St. Ste 300 Somerville, MA 02144  
City, State and Zip Code of the License Holder: \_\_\_\_\_  
Phone Number of the License Holder: 617-591-9200

Where We Should Send Mail: Name: Amethyst Chiropractic, P.C.  
Street Address: 259 Elm Street Suite 300  
City, State and Zip Code: Somerville, MA 02144

Federal ID # (Do Not Give a Social Security #): 04-3305477

Emergency Contact and his/her Phone Number: Mary Baker 617-591-9200

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

☐ Sole Proprietor: Name of Owner: \_\_\_\_\_

☐ Partnership (inc. LLP): Name of Partnership: \_\_\_\_\_

Names of All Partners Who Own More Than 10%: \_\_\_\_\_

☐ Trust: Name of Trust: \_\_\_\_\_

Names of All Trustees Who Own More Than 10%: \_\_\_\_\_

☒ Corporation: Name of Corporation: \_\_\_\_\_

Name of President: Linda S. Squires, D.C.

Name of Secretary: Same Name of Treasurer: Same

☐ LLC: Name of LLC: \_\_\_\_\_

Names of All Managers: Mary Baker Linda S Squires, D.C.

Other (Attach a Description of the Form of Ownership and the Names of the 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 Licensing Commission.**

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

License Holder Signature: 

Date 01/07 2013



City of Somerville, Massachusetts  
Finance Department, Treasury Division

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: Amethyst Chiropractic, P.C.

Address of taxpayer/applicant's business in Somerville: 259 Elm Street, Ste 300

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

Taxpayer/applicant's phone: day: 617-591-9200 evening: 617-591-9200

I, (print name) Linda S. Squires, D.C., 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 7th day of  
January, 20 13.  
(Taxpayer's signature)

**CITY'S ACKNOWLEDGEMENT**

DATE OF ISSUANCE: \_\_\_\_\_ INCLUDES RELEVANT POSTINGS THROUGH: \_\_\_\_\_

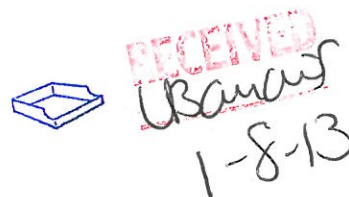
TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

☐ Real Estate ☐ Water/Sewer ☐ Personal Property ☐ Other: \_\_\_\_\_

# 4950 # 313051001 # 259 # \_\_\_\_\_

NOTES:

CLERK'S INITIALS: UB ORIGINAL STAMP:



*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: Amethyst Chiropractic, P.C.

Address: 259 Elm Street, Suite 300

City: Somerville State: MA Zip: 02144 Phone #: 617-591-9200

- |  |  |
|--|--|
| <input checked="" type="checkbox"/> I am an employer with _____ employees (full and/or part time).                             | Business Type: <input type="checkbox"/> Retail                         |
| <input type="checkbox"/> I am a sole proprietor or partnership and have no employees.  | <input type="checkbox"/> Restaurant/Bar/Eating Establishment           |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. | <input type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees.                          | <input type="checkbox"/> Nonprofit                                     |
|  | <input type="checkbox"/> Entertainment                                 |
|  | <input type="checkbox"/> Manufacturing                                 |
|  | <input checked="" type="checkbox"/> Health Care                        |
|  | <input type="checkbox"/> Other _____                                   |

**Workers' compensation insurance information (if applicable):**

Insurance Company Name: The Hartford

Address: PO Box 330

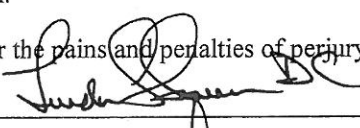
City: Clinton State: NY Zip: 13323 Phone #: 866-467-8730

Policy #: 08WECNJ9644 Expiration Date: 02/18/2013

**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:  Date: 01/07/2013

Print Name: Linda S. Squires D.C.

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

City or Town: _____	Permit/License #: _____	<input type="checkbox"/> Board of Health
		<input type="checkbox"/> Building Department
		<input type="checkbox"/> City/Town Clerk
		<input type="checkbox"/> Licensing Board
		<input type="checkbox"/> Selectmen's Office
		<input type="checkbox"/> Other _____
Contact Person: _____	Phone #: _____	