

**APPLICATION FOR OUTDOOR SEATING, GOODS  
OR OTHER PROPERTY ON CITY SIDEWALKS**

Nonrefundable Application Fee \$150.00

Date 5/13/14

FOR CITY CLERK'S OFFICE ONLY

Date Recorded \_\_\_\_\_

Amount Paid \_\_\_\_\_

☒ New Application

☐ Renewing Application with Additions or Changes

☐ Renewing Application with NO Additions or Changes

Business (DBA) Name: Perfect Dental Management Phone: 617-319-3638

Applicant's Federal Employer Identification Number: 270515197

Applicant's Legal Name: Dmitry Lintov

Applicant's Address (with Zip Code): 128 Broadway, Somerville MA

Mailing Name (where we should send correspondence to): Perfect Dental - Dmitry Lintov

Mailing Address (with Zip Code): 128 Broadway, Somerville MA 02145

Emergency Contact: Pzadorn Phone: 617-764-

3032

Type of Business (Check Only One and Provide 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: \_\_\_\_\_

Name of Secretary: \_\_\_\_\_ Name of Treasurer: \_\_\_\_\_

☒ **LLC:** Name of LLC: Perfect Dental Management

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

Dmitry Burshatyn

☐ **Other** (Attach a Description of the Form of Ownership and the Names of Owners)

2014 JUN 10 A 10:13  
CITY CLERK'S OFFICE  
SOMERVILLE, MA

Business (DBA) Name: \_\_\_\_\_

Application for:

\_\_\_\_\_ tables and \_\_\_\_\_ chairs.

☒ A-frame sign.

Other: \_\_\_\_\_

Provide a detailed description of the request, including the location of the items on the sidewalk or public way: It would be placed closer to the curb, so it doesn't interfere with people walking by.

For seating, attach a scale plan on 8½" x 11" paper, showing the location and dimensions of the seating, the sidewalk or public way, and any signs, trees, or other obstructions.

### RELEASE AND INDEMNITY AGREEMENT TO ENCUMBER A PUBLIC WAY

I, the undersigned Applicant or Duly Authorized Agent, hereby agree to release, discharge and hold harmless, the City of Somerville, a municipal corporation of the Commonwealth of Massachusetts, and its officers, employees, agents and servants from all actions, causes of action, claims, demands, damages, costs, loss of services, expenses and compensation associated with the undersigned's use of the public way as described herein.

Signature of Applicant: [Signature] Date: 5-13-14

### ACKNOWLEDGEMENT

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this license. This license will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville. 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.

Signature of Applicant: [Signature] Date: 5/13/14  
Print Name: Dmitry Linkov Phone: 617-319-3638

### FOR ALL NEW OR CHANGING APPLICATIONS:

#### CITY ENGINEER APPROVAL:

The Plan is compliant with the Americans with Disabilities Act: ☒ Yes ☐ No.

Additional conditions \*no changes to plan allowed


w/o prior approval from this office

Signature: [Signature] Name and Title: Melissa McGuire  
Acting Director

## OTHER CONDITIONS

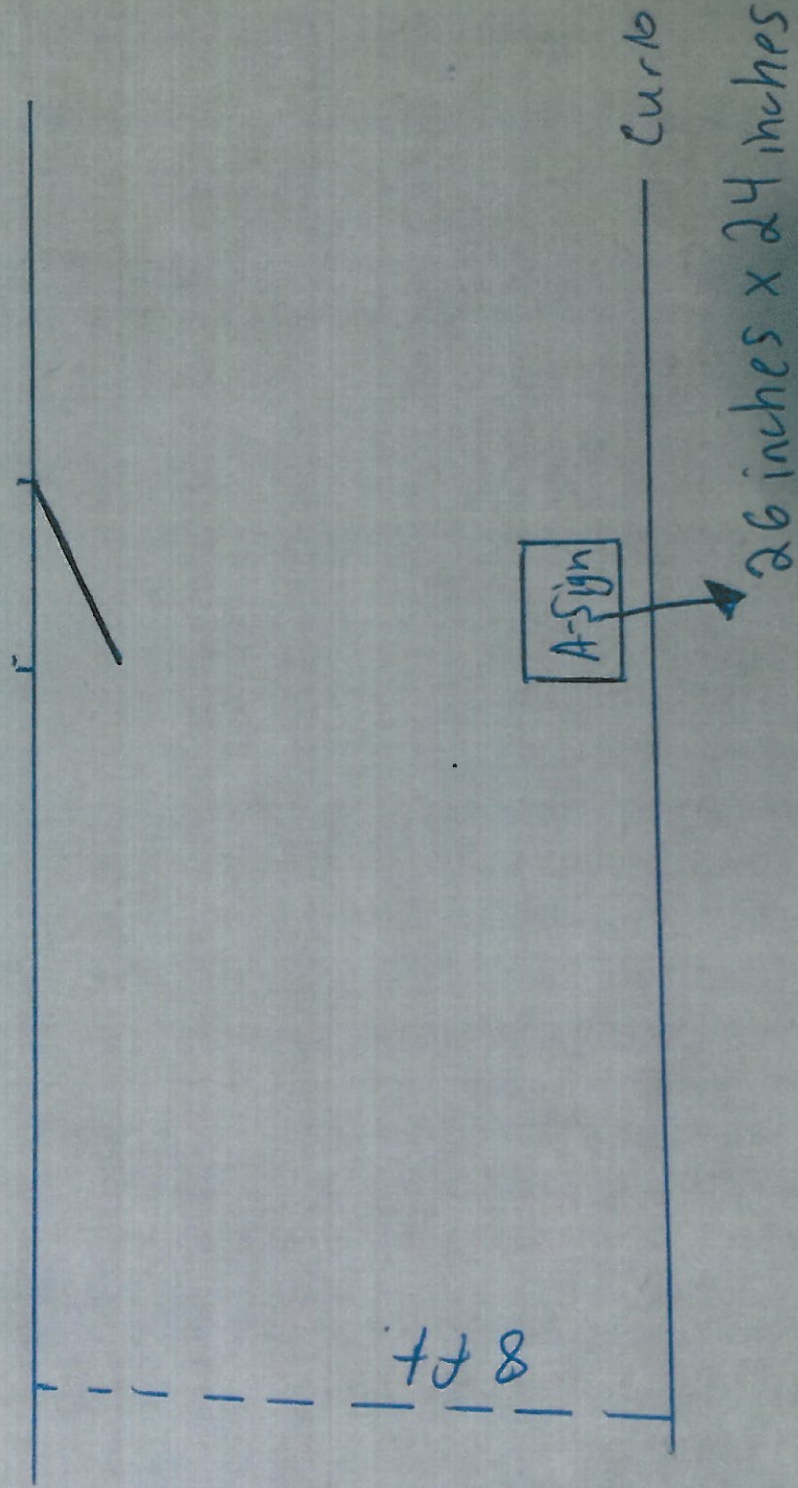
1. This permit is issued annually and is valid through December 31.
2. The Applicant agrees to use only those items described in the description and attached plan, and place all items on the sidewalk or public way in such a manner as not to obstruct pedestrian traffic and to permit an unobstructed path of travel in accordance with applicable federal and state law. The Applicant agrees to maintain a minimum clearance of 42" on the sidewalk or public way at all times.
3. The Applicant agrees to submit a City and County Licenses and Permits Bond in the amount of \$5,000, or a current Certificate of Insurance listing the City of Somerville as an Additional Insured on the business liability insurance in a form satisfactory to the City before the Permit will be issued.
4. The Applicant agrees to remove all goods and other property from the sidewalk or public way no later than 9:00 PM, except for outdoor seating, which shall be maintained per #5 below.
5. For outdoor seating,
  - a. The Applicant agrees to comply at all times with 248 CMR 10.10 (minimum toilet facilities), and hereby certifies that the Applicant has sufficient toilet facilities to accommodate the maximum indoor and outdoor seating capacity.
  - b. The Applicant agrees to install a containment system, which is satisfactory to the City, around the periphery of the outdoor seating area in order to delineate and separate the proposed use from the public sidewalk or public way.
  - c. The Applicant agrees to close all outdoor seating no later than 10:00 PM.
  - d. The Applicant acknowledges that the service of alcohol in the outdoor seating area is prohibited, and may result in criminal and/or civil sanctions, unless separately licensed by the Licensing Commission.
  - e. The Applicant agrees to the placement and regular maintenance of a trash receptacle on the sidewalk or public way in front of the business in order to minimize extra litter associated with outdoor seating.

6. \_\_\_\_\_

Signature of Applicant:  Date: 5-13-14



Perfect Dental  
128 Broadway  
Somerville MA



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
06/11/2014

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

<b>PRODUCER</b> ALD INSURANCE AGENCY, INC. 60A BRIGHTON AVE ALLSTON, MA 02134	<b>CONTACT NAME:</b> JARROD GERSTENECKER <b>PHONE (A/C, No, Ext):</b> 617-787-7877 <b>FAX (A/C, No):</b> 617-787-7876 <b>E-MAIL ADDRESS:</b> JARROD@ALDINSURANCE.COM														
<b>INSURED</b> PERFECT DENTAL LLC 85 FRANKLIN ST NEEDHAM HEIGHTS, MA 02494	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th style="text-align: left;">INSURER(S) AFFORDING COVERAGE</th> <th style="text-align: left;">NAIC #</th> </tr> <tr> <td>INSURER A: SENTINEL INSURANCE CO. LTD</td> <td>11000</td> </tr> <tr> <td>INSURER B:</td> <td></td> </tr> <tr> <td>INSURER C:</td> <td></td> </tr> <tr> <td>INSURER D:</td> <td></td> </tr> <tr> <td>INSURER E:</td> <td></td> </tr> <tr> <td>INSURER F:</td> <td></td> </tr> </table>	INSURER(S) AFFORDING COVERAGE	NAIC #	INSURER A: SENTINEL INSURANCE CO. LTD	11000	INSURER B:		INSURER C:		INSURER D:		INSURER E:		INSURER F:	
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INSURER E:															
INSURER F:															

**COVERAGES**                      **CERTIFICATE NUMBER:**                      **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE		ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	GENERAL LIABILITY			X	08 SBA PU5891	10/17/2013	10/17/2014	EACH OCCURRENCE	\$ 2,000,000
	<input checked="" type="checkbox"/>	COMMERCIAL GENERAL LIABILITY						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$ 1,000,000
	<input type="checkbox"/>	CLAIMS-MADE	<input checked="" type="checkbox"/> OCCUR					MED EXP (Any one person)	\$ 10,000
	<input type="checkbox"/>							PERSONAL & ADV INJURY	\$ 2,000,000
	<input type="checkbox"/>							GENERAL AGGREGATE	\$ 4,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:							PRODUCTS - COMP/OP AGG	\$ 4,000,000
	<input type="checkbox"/> POLICY	<input type="checkbox"/> PRO-JECT	<input checked="" type="checkbox"/> LOC						\$
	AUTOMOBILE LIABILITY							COMBINED SINGLE LIMIT (Ea accident)	\$
	<input type="checkbox"/>	ANY AUTO	<input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					BODILY INJURY (Per person)	\$
	<input type="checkbox"/>	ALL OWNED AUTOS						BODILY INJURY (Per accident)	\$
	<input type="checkbox"/>	HIRED AUTOS						PROPERTY DAMAGE (Per accident)	\$
	<input type="checkbox"/>								\$
	A	<input checked="" type="checkbox"/>	UMBRELLA LIAB					<input type="checkbox"/> OCCUR	X
<input type="checkbox"/>		EXCESS LIAB	<input type="checkbox"/> CLAIMS-MADE	AGGREGATE	\$ 1,000,000				
<input type="checkbox"/> DED		<input checked="" type="checkbox"/>	RETENTION \$10,000		\$				
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			N/A				<input type="checkbox"/> WC STATU-TORY LIMITS	<input type="checkbox"/> OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)							E.L. EACH ACCIDENT	\$
	If yes, describe under DESCRIPTION OF OPERATIONS below							E.L. DISEASE - EA EMPLOYEE	\$
								E.L. DISEASE - POLICY LIMIT	\$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

**CERTIFICATE HOLDER**

CITY OF SOMERVILLE  
 93 HIGHLAND AVE  
 SOMERVILLE, MA 02143

**CANCELLATION**

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE



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City of Somerville, Massachusetts  
Finance Department, Treasury Division

**CERTIFICATE OF GOOD STANDING**

Exact name of taxpayer/applicant's business: \_\_\_\_\_

Address of taxpayer/applicant's business in Somerville: 128<sup>130</sup> Broadway

Address of taxpayer/applicant's home in Somerville: \_\_\_\_\_

Taxpayer/applicant's phone: day: \_\_\_\_\_ evening: \_\_\_\_\_

I, (print name), 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 \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. \_\_\_\_\_  
(Taxpayer's signature)

**CITY'S ACKNOWLEDGEMENT**

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

**TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:**

<input checked="" type="checkbox"/> Real Estate	<input type="checkbox"/> Water/Sewer	<input type="checkbox"/> Personal Property	<input type="checkbox"/> Other: _____
# <u>1997</u>	# <u>101056001</u>	# <u>N/A</u>	# _____

**NOTES:**

**CLERK'S INITIALS:** Q

**ORIGINAL STAMP:** 

**RECEIVED**  
6/10/14



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

**Workers' Compensation Insurance Affidavit - General Businesses**

**Applicant information:**

Name: Perfect Dental LLC

Address: 85 Franklin St.

City: Needham Heights State: MA Zip: 02494 Phone #: 774-203-3757

- ☒ I am an employer with 67 employees Business Type: ☐ Retail  
(full and/or part time). ☐ Restaurant/Bar/Eating Establishment  
☐ Office and/or Sales (real estate, auto, etc.)  
☐ Nonprofit  
☐ Entertainment  
☐ Manufacturing  
☐ I am a sole proprietor or partnership and have no employees. ☒ Health Care  
☐ We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. ☐ Other \_\_\_\_\_  
☐ We are a nonprofit organization staffed by volunteers and have no employees.

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

Insurance Company Name: Hartford Insurance

Address: 3600 Wiseman Blvd

City: San Antonio State: TX Zip: 78251 Phone #: 800-447-7649

Policy #: 72 WEC DW9846 Expiration Date: 01/29/2015

**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: 5-15-14

Print Name: Dmitry Lihkov

*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 \_\_\_\_\_