

APPLICATION FOR EXTENDED OPERATING HOURS

Application Fee \$500.00 _____

Date _____

2010 APR 25 10:19
FOR CITY CLERK'S OFFICE ONLY
Date Recorded _____
Amount Paid \$500. - SOMERVILLE, MA

New Application

Renewing Application with Additions or Changes

Renewing Application with NO Additions or Changes

Business Name: COLORED LIGHT REST. Phone: 617-666-9822

Business DBA Name (if applicable): _____

Address with Zip Code: 24 COLLEGE AVE. SOMERVILLE MA 02144

Tax Identification Number: _____ Check one: SSN FEIN

Mailing Name (where we should send correspondence to): HO PHUNG LAM

Address with Zip Code: 24 COLLEGE AVE. SOMERVILLE MA 02144

Property Owner Name: _____ Phone: _____

Address with Zip Code: _____

Emergency Contact 1: ALEX LAM Phone: 617-216-1141

Emergency Contact 2: _____ Phone: _____

Type of Business (Check one): Sole Proprietor Partnership (inc. LLP) Trust
 Corporation (inc. LLC) Other _____

IF A SOLE PROPRIETOR:

Owner's Name: HO PHUNG LAM

Address with Zip Code: 24 COLLEGE AVE SOMERVILLE MA 02144

IF A PARTNERSHIP, TRUST OR CORPORATION (Attach additional sheets as needed):

Partner's/Member's/President's Name: _____

Address with Zip Code: _____

Partner's/Member's/Secretary's Name: _____

Address with Zip Code: _____

Partner's/Member's/Treasurer's Name: _____

Address with Zip Code: _____

Extended hours requested (include hours of operation and days of week) _____

SUNDAY - TUESDAY 9:00PM - 1:30AM.

FRIDAY - SATURDAY 5:00PM - 2:00AM.

Type of business RESTAURANT.

Length of time at this location 26 YEARS

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.

Signature of Applicant: _____ Date: _____

Print Name: HO CHUNG TAM Phone: 617-666-9822

POLICE DEPT. (for new applicants or applicants further extending their hours):

The Chief of Police recommends that the application be

Approved

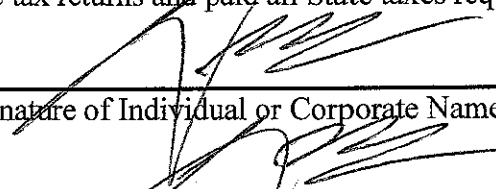
Denied

Signature: Chief Michael S. Cabral

Name and Title: Chief Michael S. Cabral

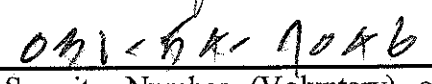
**MASSACHUSETTS DEPARTMENT OF REVENUE
REVENUE ENFORCEMENT AND PROTECTION (REAP)
ATTESTATION**

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.



*Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)



**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: HO ERING LAM.

Address of taxpayer/applicant's business in Somerville: 24 COLLEGE AVE SOMERVILLE MA.

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

Taxpayer/applicant's phone: day: 617-1194966 evening: 617-666-9822

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

April, 20 10. _____
(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: _____

19621010 # 311022001 # 08210033 # _____

NOTES:

CLERK'S INITIALS: [Signature]

ORIGINAL STAMP:

received
4-26-10

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: WOLVEN LIGHT RESTAURANT.
Address: 2A COLLEGE AVE
City: SOMERVILLE State: MA Zip: 02142 Phone #: 617-6669822

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

Workers' compensation insurance information (if applicable):

Insurance Company Name: PUBLIC SERVICE MUTUAL INSURANCE CO.
Address: ONE PARK AVE
City: NEW YORK State: NY Zip: 10016 Phone #: _____
Policy #: WC 010948 Expiration Date: JUNE 2010

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: _____
Print Name: JOSEPH JAM

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 _____