

#### CITY OF SOMERVILLE

Commonwealth of Massachusetts 93 Highland Avenue Somerville, MA 02143 (617) 625-6600

Application to Renew Garage License

SOMERVILLE AUTO CENTER, INC. 193 SOMERVILLE AV **SOMERVILLE MA 02143** 

License #:

BL15-000751

CITY CLERK' BILE #FICE SOMERVIL Fee: MA

15-634 550

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: SOMERVILLE AUTO CENTER, INC. Business Location: 193 SOMERVILLE AVE Business Phone: 617-625-7400	
<b>License Holder:</b> SOMERVILLE AUTO CENTER, INC. 193 SOMERVILLE AV SOMERVILLE MA 02143	
Mailing Address: SOMERVILLE AUTO CENTER, INC. 193 SOMERVILLE AV SOMERVILLE MA 02143	
Business Type: Corporation STANLEY DAVITORIA STANLEY DAVITORIA STANLEY DAVITORIA	
FID: 043583509	
Emergency Contact: STANLEY DAVITORIA Phone:	
Proposed Hours of Operation if outside standared hours: MO-FR 8AM-6PM, SA 8AM-2PM # of Vehicles Kept Inside: 16 # of Vehicles Kept Outside: 0 Open to the public? Yes Mechanical repairs? No Autobody work? Yes Spray Painting? Yes Washing vehicles? No Charging money to store vehicles? No Storing unregistered vehicles? No Maintaining or operating a tow vehicle at this location? No	

I hereby certify under the penalties of perjury that the following -All information shown above is true and accurate.  -Any changes above are subject to the approval of the BOA -I have filed all State taxes required.	RD OF AL	DERMEN.	ess.
Signature: Sclew (IIII)	Date:	3-26	
Printed Name: TANLEY DAVITORIA	_ Phone:_	617 62	57400



## City of Somerville, Massachusetts Finance Department, Treasury Division

#### CERTIFICATE OF GOOD STANDING

		.00	<b>.</b>	- 01/	
Exact name of taxpayer/appl	icant's business:	173	SOMERVICE	LE AVE	
Address of taxpayer/applicar	nt's business in Somer	ville:			
Address of taxpayer/applicar	nt's home in Somervill	le:			
Taxpayer/applicant's phone:	day:	ever	ning:		
I, (print name) hereby certify that all the inductive City have been paid and fees and is current on said	or that the Taxpayer	erein is true has entered	the undersigned e and correct and a into an agreemen	Taxpayer, do all taxes and fees to pay all taxes	
SIGNED UNDER THE PA					
	, 20	(T	axpayer's signatur	e)	
C	CITY'S ACKNOW	LEDGE	MENT		
DATE OF ISSUANCE: INCLUDES RELEVANT POSTINGS THROUGH:					
TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:					
☐ Real Estate	□Water/Sewer	☐ Person	al Property	☐ Other:	
# N/A	# NA	# /U	36	#	
NOTES:	OC.				
CLERK'S INITIALS:	THE STATE OF THE S	ORIGIN	AL STAMP:		

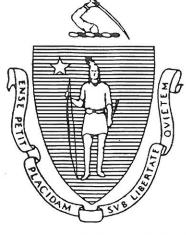
# The Commonwealth of Massachusetts Department of Industrial Accidents Office of Investigations 600 Washington Street Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Businesses

			- 2	
Applicant information:		1.		
Name: Dornerui	le Auto Ce	enter Inc		
Address: 193 So	merville	Ave		
city: Somery'lle	State: MA	Zip:02143 Phone	#:	
I am an employer with (full and/or part time).  I am a sole proprietor or part employees.  We are a corporation that has exemption per c152 s1(4), and we are a nonprofit organizat volunteers and have no employee.	nership and have no s exercised our right of nd have no employees. ion staffed by	Restaurant/Bar/Eating Office and/or Sales (r Nonprofit Entertainment Manufacturing		
Workers' compensation insura	ince information (if applica	able):	( )	
Insurance Company Name:	I rave ler's	Insurance	(Amazonia In	Surare
Address: 66 Bow	Street			
city: Somerville	State: MA	Zip:02143 Phone #	1:617 625 1900	
Policy #: 8A9635	343 UB	Expirat	ion Date: 11-13-15	
Applicant certification:				
Failure to secure coverage as repenalties of a fine up to \$1,500. WORK ORDER and a fine of forwarded to the Office of Investor	00 and/or one years' impriso \$100.00 a day against me	onment as well as civil penals. I understand that a copy	alties in the form of a STOP	
I do hereby certify/under the pair	and penalties of perjury th	at the information provided	above is true and correct.	
Signature: Signature:	Gline )	Date:	3-26-2015	
Print Name: STAN LE	4 PAVITOR	A		
	e sangrener lika dalah			
Official use only.	Do not write in this area. T	To be completed by city or to		
City or Town:	Permit/License	e#:	Board of Health Building Department City/Town Clerk Licensing Board Selectmen's Office	
Contact Person:	Phone #:		Other	

(revised Jan. 2008)

## NOTICE TO EMPLOYEES



## NOTICE TO EMPLOYEES

### The Commonwealth of Massachusetts DEPÄRTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111 617–727–4900 — http://www.mass.gov/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above mentioned chapter by insuring with:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

P.O. BOX 1450 MIDDLEBORO, MA 02344-1450

ADDRESS OF INSURANCE COMPANY

(IEUB-8A96394-3-14)

11-13-14 TO 11-13-15

POLICY NUMBER

EFFECTIVE DATES

AMAZONIA INS AGENCY INC

66 BOW ST

SOMERVILLE

MA 02143

NAME OF INSURANCE AGENT

ADDRESS

PHONE #

SOMERVILLE AUTO CENTER INC

193 SOMERVILLE AVE

SOMERVILLE MA 02143

**EMPLOYER** 

**ADDRESS** 

EMPLOYER'S WORKERS COMPENSATION OFFICER (IF ANY)

DATE

#### MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL

**ADDRESS** 

