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

Application to Renew Garage License

2015 APR -8 P 12:47

CITY CLERK'S OFFICE
SOMERVILLE, MA

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

License #: BL15-000751
File #: 15-634
Fee: 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	
License Holder: 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 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: 3-26-13

Printed Name: STANLEY DAVITORIA Phone: 617 625 7400

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: 193 SOMERVILLE AVE

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

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:

☐ Real Estate	☐ Water/Sewer	☐ Personal Property	☐ Other: ____
# N/A	# N/A	# 1036	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:**

SOMERVILLE CITY HALL • 93 HIGHLAND AVENUE • SOMERVILLE MASSACHUSETTS 02143
(617) 625-6600 EXT. 3500 • TTY: (866) 808-4851 • FAX: (617) 666-9682
WWW.SOMERVILLEMA.GOV

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: Somerville Auto Center Inc

Address: 193 Somerville Ave

City: Somerville State: MA Zip: 02143 Phone #:

☑ I am an employer with 4 employees (full and/or part time).
☐ I am a sole proprietor or partnership and have no employees.
☐ We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees.
☐ We are a nonprofit organization staffed by volunteers and have no employees.

Business Type:
☐ Retail
☐ Restaurant/Bar/Eating Establishment
☐ Office and/or Sales (real estate, auto, etc.)
☐ Nonprofit
☐ Entertainment
☐ Manufacturing
☐ Health Care
☐ Other Auto Body Shop

Workers' compensation insurance information (if applicable):

Insurance Company Name: Traveler's Insurance (Amazonia Insurance)

Address: 66 Bow Street

City: Somerville State: MA Zip: 02143 Phone #: 617 625 1900

Policy #: 8A963943 UB Expiration Date: 11-13-15

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: 3-26-2015

Print Name: STANLEY DAVITORIA

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

City or Town: _____ *Permit/License #:* _____

☐ *Board of Health*
☐ *Building Department*
☐ *City/Town Clerk*
☐ *Licensing Board*
☐ *Selectmen's Office*
☐ *Other* _____

Contact Person: _____ *Phone #:* _____

(revised Jan. 2008)

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts
DEPARTMENT 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

TO BE POSTED BY EMPLOYER

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