



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

APPLICATION TO RENEW FLAMMABLES LICENSE

THOMAS LYNCH
80 MORRISON AVENUE
SOMERVILLE, MA 02144

License #: **850**
City #F75
Fee: **550.00**
Account ID: **605**
Reference #: **850**

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: PETE'S BOY'S, INC. Business Location: 229R LOWELL ST Business Phone: 617-628-1150	
License Holder: PETE'S BOY'S, INC. 229 LOWELL ST SOMERVILLE, MA 02143 617-628-1150	
Mailing Address: THOMAS LYNCH 80 MORRISON AVENUE SOMERVILLE, MA 02144	
Business Type: CORPORATION (INC. LLC) PRESIDENT - TOM LYNCH SECRETARY - TOM LYNCH TREASURER - TOM LYNCH	
FID: 300175654	
Food Manager/Emergency Contact: TOM LYNCH 617-628-1150	

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

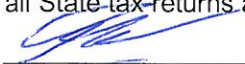
Hours: **MO-SU 5 AM - MIDNIGHT**

Description of Location and/or Other Conditions:

Originally Issued 3/22/1923, Amended 03/26/30, 02/11/54, Storage Only: 7,000 Gals. Gasoline. 1,000 Gals. Waste Oil. 500 Gals. Fuel Oil. 300 Gals. Alcohol. 1,000 Gals. Motor Oil.

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: 3/20/14
Print Name: Tom Lynch Phone: 617-628-1150



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Peter Coy's Inc

Address of taxpayer/applicant's business in Somerville: 229 Lowell St

Address of taxpayer/applicant's home in Somerville: Somerville, MA

Taxpayer/applicant's phone: day: _____ evening: _____

I, (print name) Tan Lynd, 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 21 day of MARCH, 20 14.
[Signature]
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____ INCLUDES RELEVANT POSTINGS THROUGH: _____

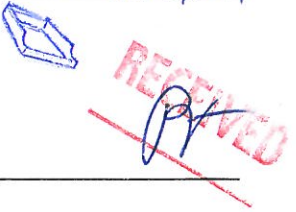
TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

Real Estate Water/Sewer Personal Property Other: _____

9299 # 228051011 # 751 # _____

NOTES:

CLERK'S INITIALS: _____



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: Rota Bjs

Address: 729 Innd St

City: Som State: MA Zip: 02144 Phone #: 617-625-1100

- | | | |
|---|--------------------------------------|--|
| <input 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 checked="" 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 type="checkbox"/> Health Care | |
| | <input type="checkbox"/> Other _____ | |

Workers' compensation insurance information (if applicable):

Insurance Company Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone #: _____

Policy #: _____ Expiration Date: _____

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: _____

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 #: _____