



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

Application to Renew Garage License

DEWIRE FAMILY TRUST
2 HOLDEN STREET
CAMBRIDGE MA 02138

License #: BL15-000775
File #: 15-658
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: DEWIRE FAMILY TRUST Business Location: 387 WASHINGTON ST Business Phone: 617-354-4679	
License Holder: DEWIRE FAMILY TRUST 2 HOLDEN STREET CAMBRIDGE MA 02138	
Mailing Address: DEWIRE FAMILY TRUST 2 HOLDEN STREET CAMBRIDGE MA 02138	
Business Type: Trust JAMES DEWIRE	
FID: 046484860	
Emergency Contact: JAMES DEWIRE Phone: 617-354-4679	
Proposed Hours of Operation if outside standard hours: MO-SA 6:30AM-6PM # of Vehicles Kept Inside: 12 # of Vehicles Kept Outside: 0 Open to the public? Yes Mechanical repairs? Yes Autobody work? No Spray Painting? No Washing vehicles? No Charging money to store vehicles? No Storing unregistered vehicles? No Maintaining or operating a tow vehicle at this location? No	

2015 APR 30 P 6:49
CITY CLERK'S OFFICE
SOMERVILLE, MA

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: James Dewire Date: April 29, 2015

Printed Name: James Dewire Phone: 617-354-4679



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Dewire Family Trust

Address of taxpayer/applicant's business in Somerville: 387 Washington Street

Address of taxpayer/applicant's home in Somerville: 2 Holden Street Cambridge Mass 02138

Taxpayer/applicant's phone: day: 617-354-4679 evening: 617-354-4679

I, (print name) James Dewire, 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 29th day of April 29, 2015. James Dewire
(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: _____

15918 # 247061001 # _____ # _____

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 Businesses

Applicant information:

Name: Dewire Family Trust

Address: 387 Washington Street

City: Somerville State: Ma Zip: 02143 Phone #: 617-354-4679

- | | |
|--|---|
| <input type="checkbox"/> I am an employer with _____ employees (full and/or part time). | Business Type: <input type="checkbox"/> Retail |
| <input checked="" type="checkbox"/> I am a sole proprietor or partnership and have no employees. | <input type="checkbox"/> Restaurant/Bar/Eating Establishment |
| <input 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 checked="" type="checkbox"/> Other <u>Motor Vehicles Storage</u> |

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: James Dewire Date: April 29, 2015

Print Name: James Dewire

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 _____