

IMPORTANT

Dear License Holder:

It is time to renew the license issued by the Somerville Board of Aldermen. We are converting to a new software system, and you will see below the information we have on file for your license. Please fill out all six boxes below with the correct information so we can update our records, and return all of the pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

License Type: Extended Operating Hours

License Number: #191179

Business Name: Mayer Campus Center

Location: 44 Professors Row

Special Conditions (if any): Sep-May, Th-Sa to 2AM,

Renewal Fee (Return with this application): \$550

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business: Mayer Campus Center

Somerville Address and Zip Code: 44 Professors Row, Somerville MA 02144

Phone Number of the Business: _____

The Legal Name of the License Holder: Trustees of Tufts College

Street Address of the License Holder: _____

City, State and Zip Code of the License Holder: _____

Phone Number of the License Holder: 617-628-5000

Email Address of the License Holder: _____

Where We Should Send Mail: Name: Tufts University Dining Services

Street Address: 89 Curtis Street

City, State and Zip Code: Somerville MA 02144

Email: patti.klos@tufts.edu

Phone Number: 617-627-3751

Federal ID # (Do Not Give a Social Security #): 042-103-634

Emergency Contact and Phone (For Fire Dept. Use): Patricia Klos 617-627-3751

-OVER-

Type of Business (Check Only One and Give the Names Indicated):

Sole Proprietor: Name of Owner: _____

Partnership (inc. LLP): Names of All Partners Who Own More Than 10%: _____

Trust: Names of All Trustees Who Own More Than 10%: _____

☒ Corporation (inc. LLC): Name of President: Anthony Monaco

Name of Secretary: Paul Tringale

Name of Treasurer: Thomas S. McGurty

Other (Attach a Description of the Form of Ownership and the Names of Owners)


ACKNOWLEDGEMENT: 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 Somerville Board of Aldermen.

-I have filed all State tax returns and paid all State taxes required by law for this business.

License Holder Signature: _____



Date 4/25/12



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Trustees of Tufts College

Address of taxpayer/applicant's business in Somerville: Mayer Campus Center, 44 Professors Row

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

Taxpayer/applicant's phone: day: 617-627-3751 evening: _____

I, (print name) Patricia L. Klos, 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 23rd day of

April, 2012. Patricia L. Klos
(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: _____

99744196 # 334020001 # _____ # _____

NOTES:

CLERK'S INITIALS: X

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: Tufts University - Dining Services
Address: 89-91 Curtis Street
City: Somerville MA State: MA Zip: 02144 Phone #: 617-627-3750

- ☒ I am an employer with 3500 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 Educational

Workers' compensation insurance information (if applicable):

Insurance Company Name: SELF INSURED
Address: _____
City: _____ State: _____ Zip: _____ Phone #: _____
Policy #: 702 Expiration Date: 6/30/2012

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: WALKER Date: 4/24/12
Print Name: JOHN WALKER

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 _____