

IMPORTANT

Dear License Holder:

CK # 0544

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: Taxi Medallion
License Number: #191532
Business Name: Victory Cab Corp
Location: N/A
Medallion(s): 56
Special Conditions (if any):

2012 JUN 20 A 8:48
CITY CLERK'S OFFICE
SOMERVILLE MA

Renewal Fee (Return with this application): \$250 per Medallion

PLEASE FILL IN ALL SIX BOXES BELOW:

The DBA Name of the Business:	VICTORY CAB CORP.
Somerville Address and Zip Code:	255 MEDFORD ST #7 - SOMERVILLE, MA 02143
Phone Number of the Business:	(617) 628-4534

The Legal Name of the License Holder:	VICTORY CAB CORP.
Street Address of the License Holder:	255 MEDFORD ST #7
City, State and Zip Code of the License Holder:	SOMERVILLE, MA 02143
Phone Number of the License Holder:	(617) 628-4534
Email Address of the License Holder:	victoryccorp@hotmail.com

Where We Should Send Mail: Name:	ETIENE AGUIAR
Street Address:	255 MEDFORD ST #7
City, State and Zip Code:	SOMERVILLE, MA - 02143
Email:	VICTORYCCORP@HOTMAIL.COM
Phone Number:	(617) 628-4534

Federal ID # (Do Not Give a Social Security #):	04-3534271
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Emergency Contact and Phone (For Fire Dept. Use):	SARA AGUIAR (617) 293-9110
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-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%: _____

X Corporation (inc. LLC): Name of President: ETIENE F. AGUIAR

Name of Secretary: SARA E. AGUIAR

Name of Treasurer: ETIENE F. AGUIAR

 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 05/02/12



not responsible

JEP

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Victory CAB Corp.

Address of taxpayer/applicant's business in Somerville: 255 MEDFORD ST #7

Address of taxpayer/applicant's home in Somerville: 255 MEDFORD ST #7

Taxpayer/applicant's phone: day: (617) 628-4534 evening: (617) 293-9110

I, (print name) ETIENE F. AGUIAR, 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 02 day of

May, 20 12.

(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: _____

23702008

118001011
118001001

823

NOTES:

CLERK'S INITIALS: UR

ORIGINAL STAMP:



RECEIVED
UBanaw
6-20-12

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:

VICTORY CAB CORP.

Address:

255 WASHINGTON ST # 7

City:

SOMERVILLE

State:

MA

Zip:

02143

Phone #:

(617) 628-4534

- ☐ I am an employer with _____ 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 TRANSPORTATION / TAXI

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:

ETIENNE AGUIAR

Date:

05/02/12

Print Name:

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 _____