NOTE: COMPLETE FORM AND FOWARD WITH FEE TO CITY CLERK' OFFICE. DO NOT RETURN FORM TO DEPARTMENT OF PUBLIC SAFTY.

THE COMMONWEALTH OF MASSACHUSETTS

DEPARTMENT OF PUBLIC SAFETY - DIVISION OF FIRE PREVENTION 1010 COMMONWEALTH AVE. BOSTON

RENEWAL APPLICATION FOR STORAGE OF FLAMMABLES LICENSE

In accordance with the provisions General Laws, the undersigned her THOMAS LYNCH 80 MORRISON AVENUE SOMERVILLE MA 02144 4444	of Chapter 148, Section 13, of the eby certifies that: Lic#: F-2012-075 B.O.A.#: 174012 Fee: \$550.00			
Restricted to: 9,800 Gallon	s Total			
Restricted as follows; AMENDED 03/26/30, 02/11/54 - STOR 7,000 GALS. GASOLINE 1,000 GALS. WASTE OIL 500 GALS. FUEL OIL 300 GALS. ALCOHOL 1,000 GALS. MOTOR OIL NEW OWNER AS OF 2003 Is the holder of the license orig				
to be situated at 00229 R LOWELL as related to the KEEPING, STORAG EXPLOSIVES. City of Somerville. Note: This Certificate of Registr license if said license was grant owner or occupant of the land license.	ST ST STACTURE, OR SALE OF FLAMMABLES OR sation must be signed by the holder of the ed prior to July 1, 1936, otherwise by the ensed.			
KINDLY CORRECT ANY ERRORS LISTED ON OUR CURRENT RECORDS ABOVE, AND COMPLETE THE LOWER SECTION OF THIS RENEWAL APPLICATION.				
Company Name: <u>PETE'S BOY'S</u> , <u>INC.</u> Company Address: <u>00229 R LOWELL ST</u>	TEL: <u>617-628-1150</u>			
City: SOMERVILLE Stat Check One: Individual: Co: Corp: _X Tru	Gov't Partner			
Owner Name: <u>THOMAS LYNCH</u> Owner Address: <u>80 MORRISON AVENUE</u>	TEL: 617-312-3936			
	State: MA Zip: 02144			
April 30, 2012. The responsibility f	eturned to the City Clerk's office by e at once. The med by the holder of the license.			
Comptume of Applicant	** Office Use Only ** Mailed			
Signature of Applicant	Taken			
Address	Received: 49/12 / 18			
Sont M 02147	\$550, Jan 2297			
City State Zip	City Clerk			

IMPORTANT

#605 268 850

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 the enclosed page shows the information we have on file for your license. Please fill out the six boxes below with the correct information, so we can update our records, and return all of pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

The DBA Name of the Business: Lete Ray's JAC				
Somerville Address and Zip Code: 239 Lowll Sf				
Phone Number of the Business: 417-628-100				
The Legal Name of the License Holder:				
Street Address of the License Holder: 8 Myrodu Au				
City, State and Zip Code of the License Holder: Somewill me				
Phone Number of the License Holder: (17-628-17)				
Email Address of the License Holder:				
Where We Should Send Mail: Name: Tar Lynd				
Street Address:				
City, State and Zip Code: Comment Me				
Email:				
Phone Number: CD-GDE-1150				
20 017 10 18				
Federal ID # (Do Not Give a Social Security #): 30-0175054				
Emergency Contact and Phone (For Fire Dept. Use): 417-638-170				
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:				
Name of Secretary: The liquid				
Name of Treasurer:				
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 4-4-2017

MASSACHUSETTS DEPARTMENT OF REVENUE

REVENUE ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all State tax returns and paid all State taxes required under law.

* Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

** Social Security Number (Voluntary) or Federal Identification Number (Mandatory, if a corporation)

^{*} This license will not be issued unless this certification clause is signed by the applicant.

^{**} Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. G.L. c. 62C s. 49A.



City of Somerville, Massachusetts Finance Department, Treasury Division

WARNING: TREASURY NEEDS FIVE BUSINESS DAYS TO PROCESS THIS FORM.

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Rota's Ray Juc-
Address of taxpayer/applicant's business in Somerville: 29 Freell 8
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
April , 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
CLERK'S INITIALS: /A ORIGINAL STAMP:



The Commonwealth of Massachusetts Department of Industrial Accidents Office of Investigations 600 Washington Street, 7th Floor

Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Businesses

31//III-UII (SIIIII CA GITTA G	lease PRINT legibly		201
name: Roll's Bogs I-	10-		
name: Roll's Boy's I- address: 229 Lowell ST			
city Somerell state:		o: Os (YY phone #	012608/10
working in any capacity. I am an employer with employees (full & par	☐ Office ☐ Sales t time). ☐ Other _	Restaurant/Bar/Eatin (including Real Estate,	Autos etc.)
I am an employer providing workers' compensation	a for my employees v	vorking on this job.	
city:	ainer de en Calledade p P	hone#:	
	Charles Control Control Table 10 To 10 To 10 To 10	olicy#	
insurance co. I am a sole proprietor and have hired the independ			lowing workers'
compensation polices: company name:			
address:	dposod 2012 osloci. Colos III po 1914 osloci.	ohone#:	ous sette out on a metabolomica. Disponistico de la companio accidente
city:		and otherwise with the open medical field. And the comment of the comment of	proprio de la filosofia de la compaña de En la compaña de la compaña
insurance co.		oolicy#	annalteruse Uniteres (Company) (Company)
company name:			
address:		phone#:	
insurance co.		policy#	
Attach additional sheet therees says Failure to secure coverage as required under Section 25A of M one years' imprisonment as well as civil penalties in the form o copy of this statement may be forwarded to the Office of Inves	tigations of the DIA for	coverage verification.	•
I do hereby certify under the pains and penalties of perjur	y that the information	provided above is true an	d correct.
Signature		Date	
Signature Print name 7 April 1 do nereby cerujy under the name and permits		Phone#	17-625-100
Commence of the Commence of th			
official use only do not write in this area to be complet city or town: Check if immediate response is required			Building Department
city or town:	permun		Licensing Board Selectmen's Office
			Health Department Other
contact person: (revised Sept. 2003)	phone #;		Otilet