

APPLICATION FOR EXTENDED OPERATING HOURS

Application Fee ~~\$300.00~~ 500.00 ~~NOV - 3~~ NOV - 3

FOR CITY CLERK'S OFFICE ONLY	
Date Recorded	<u>11/3/10</u>
Amount Paid	<u>\$500 + \$75</u>

Date 10/21/10

CITY CLERK'S OFFICE
SOMERVILLE, MA

New Application

Renewing Application with Additions or Changes

Renewing Application with NO Additions or Changes

Business Name: The Maine Thing Inc. Phone: 617-627-9100

Business DBA Name (if applicable): Papa John's Pizza

Address with Zip Code: 622 Somerville Ave MA 02143

Mailing Name (where we should send correspondence to): The Maine Thing Inc. Att. Rob Prange

Address with Zip Code: P.O. Box 308 Bowdoinham, ME 04008-0308

Emergency Contact 1: MARCIO OLIVEIRA Phone: 603-296-5237

Emergency Contact 2: SIM BENNA Phone: 774-289-7749

Type of Business (Check one):
 Individual Sole Proprietorship
 Partnership LLC Corporation

IF AN INDIVIDUAL OR SOLE PROPRIETORSHIP:

Owner's Name: _____

Address with Zip Code: _____

IF A PARTNERSHIP, LLC OR CORPORATION (Attach additional sheets as needed):

Partner's/Member's/President's Name: Terry Tyler DOB 5/5/50

Address with Zip Code: 2505 Poplar Crest Road Louisville, KY 40223

Partner's/Member's/Secretary's Name: Dennis DeWitt DOB 1/21/45

Address with Zip Code: 800 Rugby Place Louisville KY 40222

Partner's/Member's/Treasurer's Name: _____

Address with Zip Code: _____

Extended hours requested (include hours of operation and days of week) _____

Sun thru Thursday open 11AM close 2AM

Fri + Sat. open 11AM close 3AM

Type of business Pizza Delivery + take out

Length of time at this location 7 years

ACKNOWLEDGEMENT

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this license. This license will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville.

Signature of Applicant: Robert Prange Date: 10/21/10

Print Name: Robert Prange Phone: 10/21/10

POLICE DEPT. (for new applicants or applicants further extending their hours):

The Chief of Police recommends that the application be

Approved

Denied

Signature: Chief Michael Cahill

Name and Title: Chief Michael Cahill
Chief of Police

**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.

The MAINE Thing Inc.

*Signature of Individual or Corporate Name (Mandatory)

RHA [Signature]

By: Corporate Officer (Mandatory, if a corporation)

61-1370180

**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
Treasury Department
JOSEPH A. CURTATONE
MAYOR

Elizabeth A. Craveiro
CMMC/Treasurer

WARNING: TREASURY WILL NEED UP TO FIVE (5) BUSINESS DAYS TO PROCESS THIS FORM

CERTIFICATE OF GOOD STANDING

- Name of person requesting certificate: The MAINE Thing Inc.
PLEASE PRINT
- Business Location: 622 Somerville Ave Somerville MA 02143
AND/OR
- Taxpayer's Home Address: _____
Phone: Day _____ Evening _____
- Business Owner's Home Address: P.O. Box 308 Bowdoinham, ME 04008-0308
Business Owner's Phone: Day 207-653-7272 Evening: _____
- Business I.D. Number: 61 1370180

I, _____, the undersigned Taxpayer, do
Taxpayer Print Name

hereby certify that all the information contained herein is true and correct and all taxes and fees due the City have been paid and/or that the Taxpayer has entered into an agreement to pay all taxes and fees and is current on said agreement.

[Signature]
(Business/Real Estate Owner's Signature)

Robert PRANGE
PRINT Business/Real Estate Owners Name

Date of Issuance: _____ Includes Postings Through _____

Tax and Account Number(s) Included in Certificate:

RE 03139084 Water/Sewer 249004001 Personal Property 30053-750 Other _____
212094001

CLERK'S INITIALS: [Signature]

received
10-21-10

PLEASE CHECK ONE: [Signature] Business Permit OR [Signature] Building Permit



10-21-10
Not responsible
for \$100 ticket
m. Cassidy
in clerk's



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 www.mass.gov/dia

MAINE

Workers' Compensation Insurance Affidavit: General Businesses

Applicant Information

Please Print Legibly

Business/Organization Name: The MAINE Thing, INC
 Address: P.O. Box 308 Bowdoinham, ME 04008-0308
 City/State/Zip: Bowdoinham, ME 04008-0308 Phone #: 207-653-7272

Are you an employer? Check the appropriate box:

1. I am an employer with 130 employees (full and/or part-time).*
2. I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required]
3. We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]**
4. We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

Business Type (required):

5. Retail
6. Restaurant/Bar/Eating Establishment
7. Office and/or Sales (incl. real estate, auto, etc.)
8. Non-profit
9. Entertainment
10. Manufacturing
11. Health Care
12. Other _____

*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

**If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.

Insurance Company Name: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA
 Insurer's Address: ONE TOWER SQUARE
 City/State/Zip: HARTFORD, CT 06183
 Policy # or Self-ins. Lic. # ISUB-3419R38-1-70 Expiration Date: 7/6/2011

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.

Signature: [Signature] Date: 10/21/10
 Phone #: 207-653-7272

Official use only. Do not write in this area, to be completed by city or town official.

City or Town: _____ Permit/License # _____

Issuing Authority (circle one):

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office
 6. Other _____

Contact Person: _____ Phone #: _____



**WORKERS COMPENSATION
AND
EMPLOYERS LIABILITY POLICY**

TYPE V INFORMATION PAGE WC 00 00 01 (A)

**POLICY NUMBER: (ISUB-3419R38-1-10)
NEW-10**

INSURER: TRAVELERS CASUALTY INSURANCE COMPANY OF AMERICA

NCCI CO CODE: 12432

1.

INSURED:

**THE MAINE THING, INC.
PO BOX 308
BOWDOINHAM ME 04008**

PRODUCER:

**GHM AGENCY
P O BOX 649
WATERVILLE ME 04903-0649**

Insured is **A CORPORATION**

Other work places and identification numbers are shown in the schedule(s) attached.

2. The policy period is from **07-06-10** to **07-06-11 12:01 A.M.** at the insured's mailing address.

3. A. WORKERS COMPENSATION INSURANCE: Part One of the policy applies to the Workers Compensation Law of the state(s) listed here:

ME

B. EMPLOYERS LIABILITY INSURANCE: Part Two of the policy applies to work in each state listed in item 3.A. The limits of our liability under Part Two are:

Bodily Injury by Accident: \$ **500000** Each Accident
Bodily Injury by Disease: \$ **500000** Policy Limit
Bodily Injury by Disease: \$ **500000** Each Employee

C. OTHER STATES INSURANCE: Part Three of the policy applies to the states, if any, listed here:

**AL AR AZ CA CO CT DC DE FL GA HI IA ID IL IN KS KY LA MA MD MI MN
MO MS MT NC NE NH NJ NM NV NY OK OR PA RI SC SD TN TX UT VA VT WI
WV**

D. This policy includes these endorsements and schedules:

SEE LISTING OF ENDORSEMENTS - EXTENSION OF INFO PAGE

4. The premium for this policy will be determined by our Manuals of Rules, Classifications, Rates and Rating Plans. All required information is subject to verification and change by audit to be made **ANNUALLY**.

**DATE OF ISSUE: 06-24-10 NS
OFFICE: WESTBROOK ME
PRODUCER: GHM AGENCY**

172

A5130

DIRECT BILL