CITY OF SOMERVILLE

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

2015 MAR 23 A 11:13

CITY CLERK'S OFFICE
SOMERVILLE, MA

Application to Renew Garage License

D.M. AUTO BODY INC.
48 JOY ST
SOMERVILLE MA 02143

License #: BL15-000647
File #: 15-533
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: D.M. AUTO BODY INC. **Business Location:** 48 JOY ST **Business Phone:** 617-623-1111	
License Holder: D.M. AUTO BODY INC. 48 JOY ST SOMERVILLE MA 02143	
Mailing Address: D.M. AUTO BODY INC. 48 JOY ST SOMERVILLE MA 02143	
Business Type: Corporation DONALD MAZZEO LAWRENCE CARDONE LAWRENCE CARDONE	
FID: 043003275	
Emergency Contact: LAWRENCE CARDONE **Phone:** 617-823-5906	
Proposed Hours of Operation if outside standared hours: M-F 8A-7P SA 8A-2P **# of Vehicles Kept Inside:** 8 **# of Vehicles Kept Outside:** 7 **Open to the public?** Yes **Mechanical repairs?** No **Autobody work?** Yes **Spray Painting?** Yes **Washing vehicles?** No **Charging money to store vehicles?** No **Storing unregistered vehicles?** No **Maintaining or operating a tow vehicle at this location?** No	

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: Lawrence D Cardone Date: 3/20/15

Printed Name: Lawrence Cardone Phone: 617-623-1111

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: D.M. Auto Body. Inc

Address of taxpayer/applicant's business in Somerville: 48 Joy St

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

Taxpayer/applicant's phone: day: (617-623-1111 evening: (617-889-3547

I, (print name) Lawrence M Cardone, 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 20th day of March, 2015. Lawrence M Cardone
(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: ___

#00870034 #145024011 #30000239 #_____

NOTES:

CLERK'S INITIALS: VB **ORIGINAL STAMP:**

LBarros 4-3-15

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: D.M. Auto Body Inc

Address: 48 Joy St

City: Somerville State: Ma Zip: 02143 Phone #: 617-623-1111

☒ I am an employer with 6 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 Auto Repairs

Workers' compensation insurance information (if applicable):

Insurance Company Name: Utica National Insurance

Address: 201 Edgewater Place, Suite 295

City: Wakefield State: Ma Zip: 01880 Phone #: 617-354-4640

Policy #: 463932 Expiration Date: 4/01/2015

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: Lawrence M Cardone Date: 3/20/15

Print Name: Lawrence M Cardone

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* _____

(revised Jan. 2008)

NOTICE TO EMPLOYEES

NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

1 Congress Street, Suite 100, Boston, Massachusetts 02114-2017

617-727-4900 - http://www.state.ma.us/dia

As required by Massachusetts General Law, Chapter 152, Sections 21, 22 & 30, this will give you notice that I (we) have provided for payment to our injured employees under the above-mentioned chapter by insuring with:

Utica National Insurance Company of Texas

NAME OF INSURANCE COMPANY

201 Edgewater Place, Suite 295 Wakefield, MA 01880

ADDRESS OF INSURANCE COMPANY

4831932	04-01-2014	04-01-2015
POLICY NUMBER	EFFECTIVE DATES	

T Edmund Garrity & Co Inc	545 Concord Ave.-suite 16 Cambridge, MA 02138	617-354-4640
NAME OF INSURANCE AGENT	ADDRESS	PHONE #

D M AUTO BODY INC	48 JOY STREET	SOMERVILLE	MA	02143
EMPLOYER	ADDRESS			

EMPLOYER'S WORKERS' COMPENSATION OFFICER (IF ANY) DATE

MEDICAL TREATMENT

The above named insurer is required in cases of personal injuries arising out of and in the course of employment to furnish adequate and reasonable hospital and medical services in accordance with the provisions of the Workers' Compensation Act. A copy of the First Report of Injury must be given to the injured employee. The employee may select his or her own physician. The reasonable cost of the services provided by the treating physician will be paid by the insurer, if the treatment is necessary and reasonably connected to the work related injury. In cases requiring hospital attention, employees are hereby notified that the insurer has arranged for such attention at the

NAME OF HOSPITAL ADDRESS

TO BE POSTED BY EMPLOYER

WC 7506h (8-10) Wolters Kluwer Financial Services | Uniform Forms ™