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

Application to Renew Garage License

RAFAEL E. CASTILLO
141 MIDDLESEX AVENUE
MEDFORD MA 02155

License #: BL15-000735
File #: 15-618
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: RAFAEL E. CASTILLO **Business Location:** 343 MEDFORD ST **Business Phone:** 617-823-0021	
License Holder: RAFAEL E. CASTILLO 141 MIDDLESEX AVENUE MEDFORD MA 02155	
Mailing Address: RAFAEL E. CASTILLO 141 MIDDLESEX AVENUE MEDFORD MA 02155	
Business Type: Corporation	
FID: 261691140	
Emergency Contact: **Phone:**	
Proposed Hours of Operation if outside standared hours: MO-FR 6AM-8PM, SA 6AM-7PM **# of Vehicles Kept Inside:** 2 **# of Vehicles Kept Outside:** 0 **Open to the public?** Yes **Mechanical repairs?** Yes **Autobody work?** No **Spray Painting?** No **Washing vehicles?** No **Charging money to store vehicles?** Yes **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: _____ Date: 4-20-15

Printed Name: _____ Phone: _____

City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: PS Auto Service DBA Goodgas

Address of taxpayer/applicant's business in Somerville: 345 Mystic St.

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

Taxpayer/applicant's phone: day: 6177760590 evening: 7818741127
cell 6178230021

I, (print name) Rafael E Castillo, 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 28 day of April, 20 15. _____
(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: ___

9990 #20800100 1 # 810

NOTES:

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

RECEIVED
4-28-15

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

Applicant Information **Please Print Legibly**

Business/Organization Name: PCJ AUTO SERVICE DBA GOODGAS

Address: 345 MEDFORD ST.

City/State/Zip: _____ Phone #: _____

Are you an employer? Check the appropriate box:

1. ☐ I am a employer with _____ 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: THE TRAVELERS INSURANCE COMPANIES

Insurer's Address: P.O BOX 1450

City/State/Zip: MIDDLEBORO, MA 02344-1450

Policy # or Self-ins. Lic. #: JEUB-34GOR15-6-14 Expiration Date: 07-31-15

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: _____ Date: 4-28-15

Phone #: 617-823024

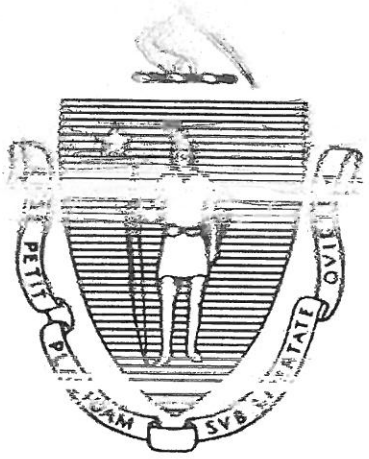
Official use only. Do not write in this area, to be completed by city or town official.

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 #:** _____

NOTICE TO EMPLOYEES



NOTICE TO EMPLOYEES

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

600 Washington Street, Boston, Massachusetts 02111

617–727–4900 — http://www.mass.gov/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:

THE TRAVELERS INSURANCE COMPANIES

NAME OF INSURANCE COMPANY

P.O. BOX 1450
MIDDLEBORO, MA 02344-1450

ADDRESS OF INSURANCE COMPANY

(IEUB-3460R15-6-14) 07-31-14 TO 07-31-15

POLICY NUMBER EFFECTIVE DATES

O DONOGHUE INS AGCY INC 90 SUMMER ST
ARLINGTON MA 02476

NAME OF INSURANCE AGENT ADDRESS PHONE #

PCJ AUTO REPAIR, INC. 345 MEDFORD 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

002630 W20P1G02