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 of Chapter 148, Section 13, of the General Laws, the undersigned hereby certifies that:
SOMERVILLE HOSPITAL Lic#: F-2010-220
230 HIGHLAND AVE, ATTN: M. LETZEISEN/PLANT OPE. B.O.A.#: 168379
SOMERVILLE MA 02143 4444 Fee: $500.00

Restricted to: 15,000 Gallons Total
Restricted as follows;
Gallons of #2 fuel oil. Subject to Fire Dept. and ISD Inspection and 30 days plan being furnished to the city

CITY CLERK'S OFFICE
SOMERVILLE, MA
2010 MAY -6 P 4:59

Is the holder of the license originally granted 02/15/2001 for the lawful use of the building (s) or other structure (s) situated or to be situated at 00230 HIGHLAND AV
as related to the KEEPING, STORAGE, MANUFACTURE, OR SALE OF FLAMMABLES OR EXPLOSIVES. City of Somerville.
Note: This Certificate of Registration must be signed by the holder of the license if said license was granted prior to July 1, 1936, otherwise by the owner or occupant of the land licensed.

____ KINDLY CORRECT ANY ERRORS LISTED ON OUR CURRENT RECORDS ABOVE, ____
AND COMPLETE THE LOWER SECTION OF THIS RENEWAL APPLICATION.

Company Name: SOMERVILLE HOSPITAL TEL: 617-591-4337
Company Address: 00230 HIGHLAND AV

City: SOMERVILLE State: MA Zip: 02143

Check One:
Individual: ___ Co: X Corp: ___ Trust: ___ Agency ___ Gov't Ship ___ Partner Other

Owner Name: SOMERVILLE HOSPITAL TEL: ____
Owner Address: 230 HIGHLAND AVE, ATTN: M. LETZEISEN/PLANT OPE.

Owner City: SOMERVILLE State: MA Zip: 02143
FID#: 042103852

This Application must be signed and filed with the required fee no later than April 30, 2010. The responsibility for filing on time is yours.
If the renewal application is not returned to the City Clerk's office by 04/30/2010 please advise this office at once.
This renewal application must be signed by the holder of the license.
Check One: Owner X Occupant ____ Holder ____

Dennis P. Keefe
Signature of Applicant

230 Highland Avenue
Attn: M Letzeisen, Plant Operations
Address

Somerville, MA 02143
City State Zip

** Office Use Only **
Mailed ____
Taken ✓

Received: $500.00 ck# 595171

5/6/10 - MS
City Clerk

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.

Somerville Hospital

* Signature of Individual or Corporate Name (Mandatory)

Dennis D. Keefe

By: Corporate Officer (Mandatory, if a corporation)

04-2103852

** 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

1. Exact name of taxpayer/applicant's business: Somerville Hospital
2. Address of taxpayer/applicant's business in Somerville: 230 Highland Avenue
3. Address of taxpayer/applicant's home in Somerville: N/A
4. Taxpayer/applicant's phone: day: 617-591-4330 evening: N/A

I, Dennis Keefe, as President, 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 15th day of April, 2010. Dennis D. Keefe
(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: _____
#2003870	#66107001 #66107002	#	#

NOTES:

CLERK'S INITIALS: MB **ORIGINAL STAMP:** received 5-6-10

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: Somerville Hospital

Address: 230 Highland Avenue

City: Somerville State: MA Zip: 02143 Phone #: 617-591-4330

☒ I am an employer with 214 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

Workers' compensation insurance information (if applicable):

Insurance Company Name: Sentry Insurance Co.

Address: 1800 North Point Drive

City: Stevens Point State: WI Zip: 54481 Phone #: 800-295-6919

Policy #: 90-15402-04 Expiration Date: 6/30/10

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: Dennis D. Keefe Date: 4/15/10

Print Name: Dennis D. Keefe

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)