CITY OF SOMERVILLE
MASSACHUSETTS
OFFICE OF THE CITY CLERK
RENEWAL APPLICATION FOR GARAGE LICENSE

ANTONIO M. MARTINS
107 WASHINGTON ST., #1
SOMERVILLE MA 02143

LIC #: 2010-232
B.O.A.# 179943

*** ENCLOSED IS THE RENEWAL CERTIFICATE FOR YOUR ***

ALLOWED USES - (CHOOSE ALL THAT APPLY)
Mechanical Repair: X Auto Body Work: ___ Parking or Storing Vehicles: ___
Washing Vehicles: ___ Spray Painting: ___ Operating a Tow Vehicle: ___

ISSUED IN ACCORDANCE WITH THE APPLICABLE PROVISIONS OF M.G.L.A. CHP. 148 Sec 13
This Certificate must be signed and filed with the required fee of $500.00 not later than April 30, 2010. Use the enclosed envelope.
Kindly fill in the information correcting any errors listed on our current records below. Please print or type your information, except for signature.

Company Name: COUNTY AUTO REPAIR, INC. TEL: _____
Company Address: 00107 WASHINGTON ST
City: SOMERVILLE State: MA Zip: 02143

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

Owner Name: ANTONIO M. MARTINS TEL: 617-628-7115
Owner Address: 107 WASHINGTON ST., #1
Owner City: SOMERVILLE State: MA Zip: 02143
FID#: 20-27-042

This renewal is being sent to you as a courtesy, please file on time. If this renewal is not returned to City Clerk's office by 04/30/2010, please advise.

***** HOURS OF OPERSTIONS *****
MONDAY-FRIDAY: 09:00 AM-05:00 PM
SATURDAY: 08:00 AM-12:00 PM
SUNDAY: CLOSED

Very truly yours,

John J. Long
City Clerk

CITY CLERK'S OFFICE SOMERVILLE, MA 2010 MAY -4 A 9:02

---------- OUR CURRENT INFORMATION SHOWS ----------
-- GARAGE OPEN TO THE PUBLIC -- LICENSE #: 2010-232
FEE: $500.00

This is to certify: ANTONIO M. MARTINS
has been licensed by the Mayor and the Aldermen of the City of Somerville.
Since 11/22/2005
Garage situated at: 00107 WASHINGTON ST
Doing business as : COUNTY AUTO REPAIR, INC.
Shall not exceed: 4 Vehicles Inside
in addition the following restrictions apply:
APPROVED AS AMENDED: 1. HOURS OF OPERATION
2. NO SPRAY PAINTING

CITY CLERK'S OFFICE SOMERVILLE, MA 2010 APR 29 A 9:40

This renewal certificate must be signed by the holder of the license.
Check One: Owner ✓ Occupant _____ Holder _____

Signature of Applicant

103 WASHINGTON ST
Address

SOMERVILLE MA 02143
City State Zip

** Office Use Only **
Mailed _____
Taken ✓

Received: 5/4/10 500.00

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.

* Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

202-704-235

** 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.

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: ANTONIO MARTINS

Address: 107 WASHINGTON ST

City: SOMERVILLE State: MA Zip: 02143 Phone #: 617 440 5646

☐ I am an employer with _____ 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: THE HARTFORD

Address: P.O.BOX 3556

City: ORLANDO State: FL Zip: 32802-3556 Phone #: 1800.453.9843

Policy #: 06 25 N 419 Expiration Date: 04/14/11

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: [signature] Date: 2/22/10

Print Name: ANTONIO MARTINS

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

*City or Town:*_____ *Permit/License #:* _____

☐ *Board of Health*
☐ *Building Department*
☐ *City/Town Clerk*
☐ *Licensing Board*
☐ *Selectmen's Office*
☐ *Other* _____

Contact Person: _____ *Phone #:* _____

(revised Jan. 2008)

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: ANTONIO MARTINS
2. Address of taxpayer/applicant's business in Somerville: 103 WASHINGTON ST ~~#2~~ SOM MA 02143
3. Address of taxpayer/applicant's home in Somerville: 107 WASHINGTON ST #1 SOM MA 02143
4. Taxpayer/applicant's phone: day: 617 628.3600 evening: 617 440.5646

I, ANTONIO MARTINS, 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 4/22/10 day of _____, 2010.

_____
(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: _____
# 01019200	# 10911000	# 00000444	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** received 4-5-10

Per Lee B.

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:

HARTFORD UNDERWRITERS INSURANCE COMPANY

NAME OF INSURANCE COMPANY

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

ADDRESS OF INSURANCE COMPANY

(6S60UB-0625N41-9-10) 04-14-10 TO 04-14-11

POLICY NUMBER EFFECTIVE DATES

COLBURN RIDER INS AGCY PO BOX 537

EAST BRIDGEWATER MA 02333

NAME OF INSURANCE AGENT ADDRESS PHONE #

COUNTY AUTO REPAIR INC 103 WASHINGTON ST

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

004259 W20P1G02