



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

2016 APR -7 A 9:32

CITY CLERK'S OFFICE
SOMERVILLE, MA

Application to Renew Garage License

Real Auto Shop Inc.
463 McGrath Highway
Somerville MA 02145

License #: BL15-001178
File #: 15-013623
Fee: 605

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: Real Auto Shop, Inc. Business Location: 463 MCGRATH HWY Business Phone: 617-764-3802	
License Holder: Real Auto Shop Inc. 463 McGrath Highway Somerville MA 02145	
Mailing Address: Real Auto Shop Inc. 463 McGrath Highway Somerville MA 02145	
Business Type: Corporation Joao Pinto Joao Pinto Joao Pinto	
FID: 208523038	
Emergency Contact: Joao Pinto Phone: 617-935-9900	
Proposed Hours of Operation if outside standard hours: Mon-Fri 9AM-7PM, Sat 10AM-3PM, Sun Closed. # of Vehicles Kept Inside: 4 # of Vehicles Kept Outside: 0 Open to the public? Yes Mechanical repairs? Yes Autobody work? No Spray Painting? No Washing vehicles? Yes Charging money to store vehicles? No Storing unregistered vehicles? Yes 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.



City of Somerville, Massachusetts
Finance Department, Treasury Division

CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: JOAO B. SILVA PINTO

Address of taxpayer/applicant's business in Somerville: 463 MCGRATH HWY

Address of taxpayer/applicant's home in Somerville: 59 GREENWOOD ST, APT 2
MELROSE, MA 02176

Taxpayer/applicant's phone: day: 617-935-9900 evening: SAME

I, (print name) JOAO BATISTA SILVA PINTO, 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 07 day of
APRIL, 2016. [Signature]
(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: _____

9952 # 146043001 # [Signature] # _____

NOTES:

CLERK'S INITIALS: _____

ORIGINAL STAMP:

Received
4-7-16

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Business

Applicant information:

Name: REAL AUTO SHOP INC.
Address: 463 MCGRATH HWY
City: SOMERVILLE State: MA Zip: 02143 Phone #: 617-764-3802

- ☐ 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: ACADIA INSURANCE COMPANY
Address: P.O. BOX 59143
City: MINNEAPOLIS State: MN Zip: 55459 Phone #: 508-853-2400
Policy #: MAARP300704 Expiration Date: 10-15-16

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: 04-07-16

Print Name: JOAO BATISTA SILVA PINHO

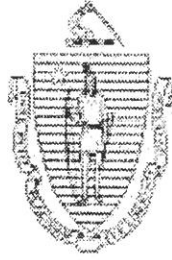
Official use only. Do not write in this area. To be completed by city or town official.

City or Town: _____ Permit/License #: _____

Contact Person: _____ Phone #: _____

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

**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:

Acadia Insurance Company

NAME OF INSURANCE COMPANY

P.O. Box 59143, Minneapolis, MN 55459-0143

ADDRESS OF INSURANCE COMPANY

MAARP300704

POLICY NUMBER

10/15/2015

EFFECTIVE DATES

Fisher Insurance Agency Inc 1099 Pleasant St Ste 5 Worcester, MA 01606

NAME OF INSURANCE AGENT ADDRESS

5088532400

PHONE #

Real Auto Shop Inc, 59 Greenwood Street Apt. 2, Melrose, MA 02176

EMPLOYER

ADDRESS

10/21/2015

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