

APPLICATION FOR A SIGN OR AWNING OVER A PUBLIC WAY

2012 SEP 27 P 4: 19

Application Fee \$250.00

FOR CITY CLERK'S OFFICE ONLY

Date

CITY CLERK'S OFFICE  
SOMERVILLE, MA

Date Recorded 9/27/12  
Amount Paid \$250-

New Sign, Awning or Advertising Device

New Facing on an Existing Frame

Renewing Existing Sign, Awning or Advertising Device Permit for a New Owner

Business Name: Davis Square Salon, Inc  
Delaria Salon Phone: 617 623 0440

Business DBA Name (if applicable): Deliana Salon

Address with Zip Code: 267 Elm St, Somerville, MA 02144

Tax Identification Number: 45-5429586 Check one:  SSN  FEIN

Mailing Name (where we should send correspondence to): Tabitha McEllan, Deliana Salon

Address with Zip Code: 159 Cambridge St, Boston MA 02134

Property Owner Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

Emergency Contact 1: Tabitha McEllan Phone: 617 254 1004 x23

Emergency Contact 2: \_\_\_\_\_ Phone: \_\_\_\_\_

Type of Business (Check one):  Sole Proprietor  Partnership (inc. LLP)  Trust  
 Corporation (inc. LLC)  Other \_\_\_\_\_

IF A SOLE PROPRIETOR:

Owner's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

IF A PARTNERSHIP, TRUST OR CORPORATION (Attach additional sheets as needed):

Partner's/Member's/President's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

Partner's/Member's/Secretary's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

Partner's/Member's/Treasurer's Name: \_\_\_\_\_

Address with Zip Code: \_\_\_\_\_

Name of company erecting sign: FLAGRAPHICS INC  
Phone: 617-776-7549

Detailed description and location of the sign, awning, or advertising device. Attach a sketch. \_\_\_\_\_  
Awning to attach with 2 clips to  
existing frame on facade of Bldg.

**ACKNOWLEDGEMENT**

I hereby state that all information provided on this application is true and accurate, and I understand that any information that is found to be false or misleading may result in the forfeiture of this permit. This permit will be subject to all of the terms, conditions, and limitations set forth in the Somerville Code of Ordinances, any applicable State and Federal laws, and any conditions prescribed by the City of Somerville.

Signature of Applicant: [Signature] Date: 9/26/12  
Print Name: Tabitha McKellan Phone: 617 254 1004 x23

**INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:**

The Inspectional Services Department recommends:  Approval  Denial  
This sign or awning is to be installed in a historic district:  True  False  
Signature: Eddie Nizzo Date: Sept 28 - 2012

**HISTORIC PRESERVATION COMMISSION RECOMMENDATION:**  
(only required for signs or awnings in historic districts)

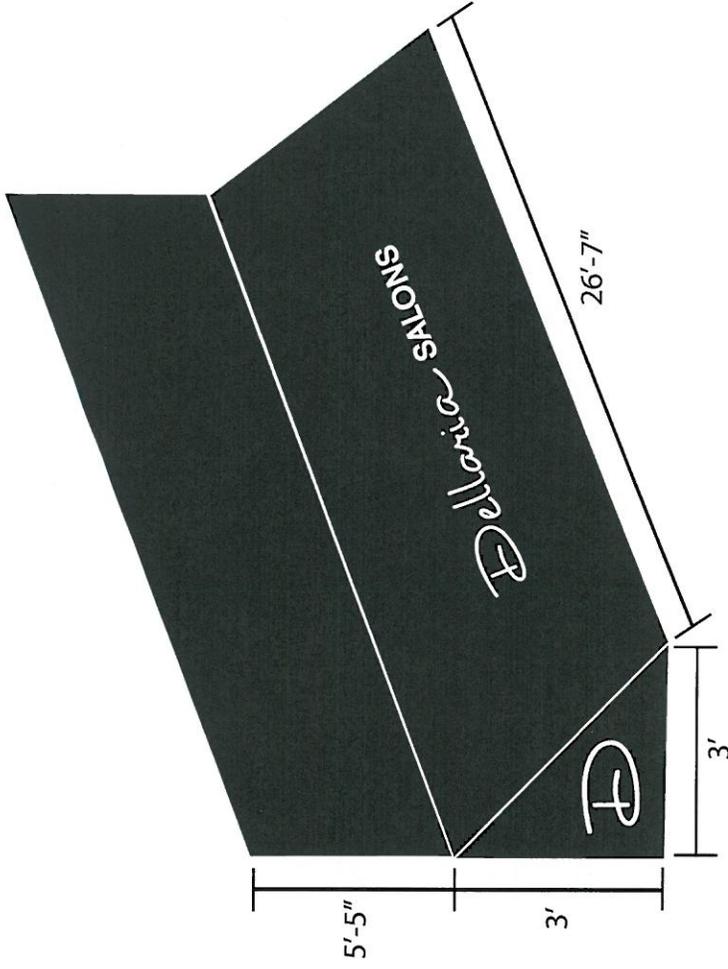
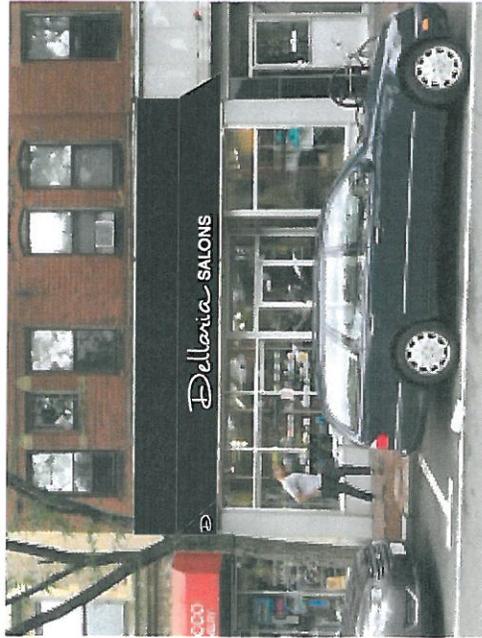
The Historic Preservation Commission recommends  Approval  Denial  
Signature: \_\_\_\_\_ Date: \_\_\_\_\_



CCO  
JEWELRY

Grand Opening!  
*Dellaria* SALONS

26



30 ALSTON STREET, SOMERVILLE, MA 02134  
 (617) 776-7549

Project: Dellaria Salons

Salesman:

Designer:

Scale:

Date: Sketch #:

Location:

Job Description:  
 Awning

File Name:

Revised

Note: This is an original drawing created by and owned by Flagraphics, Inc. It is submitted for your personal use in connection with a project being planned for you by Flagraphics, Inc. It is not to be shown to anyone outside your organization, nor is it to be used, reproduced, copied, or exhibited in any fashion.

Customer Approval:



# CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)  
9/27/2012

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

**IMPORTANT:** If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER <b>Aronson Insurance Agency Inc</b> 950 Highland Ave  Needham MA 02494	CONTACT NAME: <b>Fred Brugman, CPCU, APA</b>
	PHONE (A/C No. Ext): <b>(781) 444-3050</b> FAX (A/C No.): <b>(781) 444-3051</b>
	E-MAIL ADDRESS: <b>Fred@Aronsoninsurance.com</b>
	INSURER(S) AFFORDING COVERAGE
	INSURER A: <b>Quincy Mutual Ins Co</b> NAIC # <b>15067</b>
	INSURER B: <b>Star Insurance Co</b>
	INSURER C:
	INSURER D:
	INSURER E:
	INSURER F:

COVERAGES CERTIFICATE NUMBER: 2011-2012 REVISION NUMBER:

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR		BO087687	12/15/2011	12/15/2012	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 50,000 MED EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER: <input checked="" type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC					
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$
	UMBRELLA LIAB <input type="checkbox"/> OCCUR EXCESS LIAB <input type="checkbox"/> CLAIMS-MADE DED \$ RETENTION \$					EACH OCCURRENCE \$ AGGREGATE \$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	WC0126182	5/15/2012	5/15/2013	WC STATUTORY LIMITS OTHER E.L. EACH ACCIDENT \$ 1,000,000 E.L. DISEASE - EA EMPLOYEE \$ 1,000,000 E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)  
For Location: Davis Sq Salon, 267 Elm St, Somerville MA 02144

City of Somerville is an additional insured on the general liability per written contract

## CERTIFICATE HOLDER

City of Somerville  
93 Highland Ave  
Somerville, MA 02143

## CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

S Aronson, CIC/TRICIA

**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.

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\*Signature of Individual or Corporate Name (Mandatory)



By: Corporate Officer (Mandatory, if a corporation)

FD# 45-5429582

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\*\*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**

Exact name of taxpayer/applicant's business: \_\_\_\_\_

Address of taxpayer/applicant's business in Somerville: 257 ELM ST X

Address of taxpayer/applicant's home in Somerville: \_\_\_\_\_

Taxpayer/applicant's phone: day: \_\_\_\_\_ evening: \_\_\_\_\_

I, (print name), 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 \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

(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: \_\_\_\_\_

# 04214125      # 64107600      # \_\_\_\_\_      # \_\_\_\_\_  
4440

NOTES:

CLERK'S INITIALS:   a  

ORIGINAL STAMP: 

**RECEIVED**  
9-26-12

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:

Fill this out.

Name: Dans Square Inc d/b/a Deliana  
 Address: 267 Elm Street  
 City: Sauverville State: MA Zip: 02144 Phone #: 617.623.0666

- I am an employer with 6 employees Business Type:  Retail  
 (full and/or part time).  Restaurant/Baw/Eating Establishment  
 I am a sole proprietor or partnership and have no employees.  Office and/or Sales (real estate, auto, etc.)  
 We are a corporation that has exercised our right of exemption per c152 s(4), and have no employees.  Nonprofit  
 We are a nonprofit organization staffed by volunteers and have no employees.  Entertainment  
 Manufacturing  
 Health Care  
 Other

Workers' compensation insurance information (if applicable):

Fill out. Complete policy # from insurance

Insurance Company Name: \_\_\_\_\_  
 Address: SEE ATTACHED  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Policy #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

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.

Fill this out

Signature: Mino Micozzi Date: 7-27-12  
 Print Name: MINO MICOZZI

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)



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	E-MAIL ADDRESS: Fred@Aronsoninsurance.com
	INSURER(S) AFFORDING COVERAGE
	INSURER A: Quincy Mutual Ins Co NAIC # 15067
	INSURER B: Star Insurance Co
	INSURER C:
	INSURER D:
	INSURER E:
	INSURER F:

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	<input type="checkbox"/> CLAIMS-MADE <input checked="" type="checkbox"/> OCCUR						MED EXP (Any one person) \$ 5,000
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	AUTOMOBILE LIABILITY						PRODUCTS - COMP/OP AGG \$ 2,000,000
	ANY AUTO						COMBINED SINGLE LIMIT (Ea accident) \$
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	HIRED AUTOS						BODILY INJURY (Per accident) \$
	SCHEDULED AUTOS						PROPERTY DAMAGE (Per accident) \$
	NON-OWNED AUTOS						\$
	UMBRELLA LIAB						EACH OCCURRENCE \$
	EXCESS LIAB						AGGREGATE \$
	DED						\$
	RETENTION \$						\$
B	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY			WC0126182	5/15/2012	5/15/2013	WC STATUTORY LIMITS
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)		N/A				E.L. EACH ACCIDENT \$ 1,000,000
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE \$ 1,000,000
							E.L. DISEASE - POLICY LIMIT \$ 1,000,000

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)  
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<b>CERTIFICATE HOLDER</b>  City of Somerville 93 Highland Ave Somerville, MA 02143	<b>CANCELLATION</b>  SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.
	AUTHORIZED REPRESENTATIVE  S Aronson, CIC/TRICIA 



**The Commonwealth of Massachusetts  
William Francis Galvin**

Secretary of the Commonwealth, Corporations Division  
One Ashburton Place, 17th floor  
Boston, MA 02108-1512  
Telephone: (617) 727-9640

**DAVIS SQUARE SALON, INC. Summary Screen**



Help with this form

Request a Certificate

The exact name of the Domestic Profit Corporation: DAVIS SQUARE SALON, INC.

Entity Type: Domestic Profit Corporation

Identification Number: 455429586

Date of Organization in Massachusetts: 06/06/2012

Current Fiscal Month / Day: 12 / 31

**The location of its principal office:**

No. and Street: 159 CAMBRIDGE STREET  
City or Town: ALLSTON State: MA Zip: 02134 Country: USA

**If the business entity is organized wholly to do business outside Massachusetts, the location of that office:**

No. and Street:  
City or Town: State: Zip: Country:

**Name and address of the Registered Agent:**

Name: NINO MICOZZI  
No. and Street: 159 CAMBRIDGE STREET  
City or Town: ALLSTON State: MA Zip: 02134 Country: USA

**The officers and all of the directors of the corporation:**

Title	Individual Name First, Middle, Last, Suffix	Address (no PO Box) Address, City or Town, State, Zip Code	Expiration of Term
PRESIDENT	NINO MICOZZI	159 CAMBRIDGE STREET ALLSTON, MA 02134 USA	
TREASURER	NINO MICOZZI	159 CAMBRIDGE STREET ALLSTON, MA 02134 USA	
SECRETARY	LUIGI DEPALMA	159 CAMBRIDGE STREET ALLSTON, MA 02134 USA	
CEO	NINO MICOZZI	159 CAMBRIDGE STREET ALLSTON, MA 02134 USA	
DIRECTOR	NINO MICOZZI	159 CAMBRIDGE STREET ALLSTON, MA 02134 USA	