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:

FRANK SPINOSA — Lic#: F-2012-030
11 HASTINGS ROAD — B.O.A.#: 149580
WINCHESTER MA 01890 4444 — Fee: $550.00

Restricted to: 22,600 Gallons Total
Restricted as follows;
AMENDED 07/14/27, 01/14/32, 06/09/55, 06/18/57,11/2/88

28,000 GALS GASOLINE/DIESEL	500 GALS WASTE OIL
130 GALS GREASE	500 GALS MOTOR OIL
600 GALS LUB OIL	170 GALS ANTI-FREEZE
220 GALS KEROSENE	500 A.T.F
120 GALS ALCOHOL	

Is the holder of the license originally granted 04/11/1927 for the lawful use of the building (s) or other structure (s) situated or to be situated at 00583 BROADWAY
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: HILLSIDE AUTO REPAIR, INC. TEL: 781-395-9679
Company Address: 00583 BROADWAY

City: SOMERVILLE State: MA Zip: 02145

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

Owner Name: FRANK SPINOSA TEL: 781-756-0601
Owner Address: 11 HASTINGS ROAD

Owner City: WINCHESTER State: MA Zip: 01890
FID#: 042911681

This Application must be signed and filed with the required fee no later than April 30, 2012. The responsibility for filing on time is yours.
If the renewal application is not returned to the City Clerk's office by 04/30/2012 please advise this office at once.
This renewal application must be signed by the holder of the license.
Check One: Owner ✓ Occupant _____ Holder _____

Signature of Applicant

11 HASTINGS RD
Address

WINCHESTER MA 01890
City State Zip

** Office Use Only **
Mailed _____
Taken ✓

Received: 4/6/12 - 1105

$550.00 ck# 14303
City Clerk

IMPORTANT

#399
REF 505

Dear License Holder:

It is time to renew the license issued by the Somerville Board of Aldermen. We are converting to a new software system, and the enclosed page shows the information we have on file for your license. Please fill out the six boxes below with the correct information, so we can update our records, and return all of pages with your fee to the City Clerk's Office. Call us at 617 625-6600 x4100 if you have any questions.

The DBA Name of the Business: HILLSIDE AUTO REPAIR INC.
Somerville Address and Zip Code: 583 BROADWAY SOMERVILLE MA 02145
Phone Number of the Business: 781-395-9679

The Legal Name of the License Holder: FRANK SPINOSA
Street Address of the License Holder: 11 HASTINGS RD
City, State and Zip Code of the License Holder: WINCHESTER MA. 01890
Phone Number of the License Holder: 617 212 9413
Email Address of the License Holder: FSPINOSA @ COMCAST. NET

Where We Should Send Mail: Name: HILLSIDE AUTO REPAIR INC.
Street Address: 583 BROADWAY
City, State and Zip Code: SOMERVILLE MA. 02145
Email: HILLSIDE AUTO @ COMCAST. NET
Phone Number: 781 395-9679

Federal ID # (Do Not Give a Social Security #): 042 911 681

Emergency Contact and Phone (For Fire Dept. Use): 617 212 9413

Type of Business (Check Only One and Give the Names Indicated):

___Sole Proprietor: Name of Owner:

___Partnership (inc. LLP): Names of All Partners Who Own More Than 10%:

___Trust: Names of All Trustees Who Own More Than 10%:

_✓_Corporation (inc. LLC): Name of President: FRANK SPINOSA
Name of Secretary: BETHANN SPINOSA
Name of Treasurer: BETHANN SPINOSA

___Other (Attach a Description of the Form of Ownership and the Names of Owners)

ACKNOWLEDGEMENT: 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 Somerville Board of Aldermen.
-I have filed all State tax returns and paid all State taxes required by law for this business.

License Holder Signature: _____ **Date** 3-31-12

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.

HILLSIDE AUTO REPAIR INC.

* Signature of Individual or Corporate Name (Mandatory)

PRESIDENT

By: Corporate Officer (Mandatory, if a corporation)

042 911 681

** 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: HILLSIDE AUTO REPAIR INC.

Address of taxpayer/applicant's business in Somerville: 583 BROADWAY SOMERVILLE

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

Taxpayer/applicant's phone: day: 617-212 9413 evening: 617 212 9413

I, (print name) FRANK SPINOSA, 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~~ 31st day of MARCH, 2012.

(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: ___
# 1856143 2174	# 30202401	# 241	#

NOTES:

CLERK'S INITIALS: _____ **ORIGINAL STAMP:** RECEIVED 4-6-12

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street, 7th Floor
Boston, Mass. 02111

Workers' Compensation Insurance Affidavit - General Businesses

Applicant information: Please PRINT legibly

name: _____

address: _____

city _____ state: _____ zip: _____ phone # _____

work site location (full address): _____

☐ I am a sole proprietor and have no one working in any capacity.

Business Type: ☐ Retail ☐ Restaurant/Bar/Eating Establishment ☐ Office ☐ Sales (including Real Estate, Autos etc.)

☐ I am an employer with _____ employees (**full** & part time). ☐ Other _____

☐ I am an employer providing workers' compensation for my employees working on this job.

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

☐ I am a sole proprietor and have hired the independent contractors listed below who have the following workers' compensation polices:

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

company name: _____

address: _____

city: _____ **phone #:** _____

insurance co. _____ **policy #** _____

Attach additional sheet if necessary.

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 _____ Date 3/31/12

Print name FRANK SPINOSA Phone # 617-212 9413

official use only do not write in this area to be completed by city or town official

city or town: _____ permit/license # _____

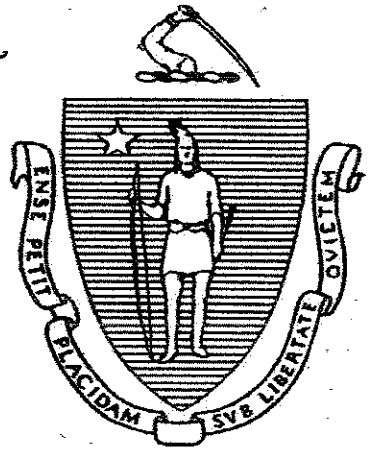
☐ Building Department
☐ Licensing Board
☐ Selectmen's Office
☐ Health Department
☐ Other _____

☐ check if immediate response is required

contact person: _____ phone #: _____

(revised Sept. 2003)

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

(IOUB-4A29001-0-11) 07-14-11 TO 07-14-12

POLICY NUMBER EFFECTIVE DATES

AUTOMATIC DATA PROC INS 1 ADP BLVD MS 325

ROSELAND NJ 07068

NAME OF INSURANCE AGENT ADDRESS PHONE #

HILLSIDE AUTOMOTIVE REPAIR INC 583 BROADWAY

SOMERVILLE
MA 02145

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

000217 W20P1G02