



**CITY OF SOMERVILLE
BOARD OF ALDERMEN**
93 HIGHLAND AVENUE
SOMERVILLE, MA 02143
(617) 625-6600

APPLICATION TO RENEW GARAGE LICENSE

SOMERVILLE AUTO CENTER, INC.
193 SOMERVILLE AV
SOMERVILLE, MA 02143

License #: 751
City #G86
Fee: 550.00
Account ID: 634
Reference #: 751

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: For SOMERVILLE AUTO CENTER, INC. Business Location: 193 SOMERVILLE AVE Business Phone: 617-625-7400	
License Holder: SOMERVILLE AUTO CENTER, INC. 193 SOMERVILLE AV SOMERVILLE, MA 02143 617-625-7400	
Mailing Address: SOMERVILLE AUTO CENTER, INC. SOMERVILLE, MA 02143	
Business Type: CORPORATION (INC. LLC) STANLEY DAVITORIA (ALL)	
FID: 043583509	
Food Manager/Emergency Contact:	

Conditions: (to change any conditions, submit a new application. Contact the City Clerk's Office for more information)

Hours: **MO-FR 8AM-6PM, SA 8AM-2PM**

OPEN TO THE PUBLIC

1 AUTO BODY WORK
1 SPRAY PAINTING
16 VEHICLES
16 VEHICLES INSIDE

Description of Location and/or Other Conditions:

Originally Issued 4/9/1925, All Vehicles Serviced Inside Only. All Vehicles Stored Within Property Line. No Parking On Somerville Avenue, No Blocking Any Sidewalk Or Street Including During Snow Removal. No Mechanical Repairs. No Washing Vehicles. No Operating Tow Vehicles.

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.

-I have filed all State tax returns and paid all State taxes required by law for this business.

Signature: *Stanley Davitoria* Date: 5-13-13
Print Name: STANLEY DAVITORIA Phone: 617-839-2542



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: Somerville Auto Center Inc

Address of taxpayer/applicant's business in Somerville: 193 Somerville Ave
Somerville, MA 02143

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

Taxpayer/applicant's phone: day: 617 625 7400 evening: 617 839 2542

I, (print name) STANLEY DAVITORIA, 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 5 day of

May, 20 13. [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: _____

13625 # 120025021 # 1085 # _____

NOTES:

CLERK'S INITIALS: [Initials] **RECEIVED** ORIGINAL STAMP:



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: Somerville Auto Center Inc
address: 193 Somerville Ave
city: Somerville state: MA zip: 02143 phone # 617 625 7400

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 3 employees (full & part time). ☐ Other _____
☐ I am an employer providing workers' compensation for my employees working on this job.

company name: TRAVELERS INS. COMPANY
address: _____
city: _____ phone #: _____
insurance co. Travelers Insurance policy # 1HUB-8A96394-3-12

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

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 Stanley Davitola Date 5-6-13
Print name STANLEY DAVITOLA Phone # 617-625 7400

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

city or town: _____ permit/license # _____
☐ check if immediate response is required
contact person: _____ phone #: _____
(revised Sept. 2003)

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