

APPLICATION FOR A JUNK DEALER LICENSE

Application Fee \$250.00

Date 4/9/10

FOR CITY CLERK'S OFFICE ONLY

Date Recorded 4/22/10 - MS

Amount Paid \$250.00 4/22/10

☐ New Application

☐ Renewing Application with Additions or Changes

☒ Renewing Application with NO Additions or Changes

Business Name: SUNSHINE LUCY'S Phone: 617-776 2011

Business DBA Name (if applicable): EDIMAR LOUZADA d/b/a

Address with Zip Code: 93 HOLLAND ST. SOMERVILLE MA 02144

Tax Identification Number: _____ Check one: ☐ SSN ☐ FEIN

Mailing Name (where we should send correspondence to): SAME

Address with Zip Code: _____

Property Owner Name: LYNDA KRAMER Phone: _____

Address with Zip Code: 79 SARGENT ROAD

Emergency Contact 1: EDDIE LOUZADA Phone: 617-8958129

Emergency Contact 2: LUCY LOUZADA Phone: 617-9613324

Type of Business (Check one): ☒ Sole Proprietor ☐ Partnership (inc. LLP) ☐ Trust
☐ Corporation (inc. LLC) ☐ Other _____

IF A SOLE PROPRIETOR:

Owner's Name: Eddie LOUZADA

Address with Zip Code: 12 KNOLLWOOD Rd MEDFORD-MA 02155

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: _____

2010 APR 22 A 8:56
CITY CLERK'S OFFICE
SOMERVILLE, MA

Will you lend money on the security of personal property lent to you?

Yes

☒ No

Will you operate as a pawnbroker?

Yes

☒ No

Describe your business plan: SELLING USED FURNITURE ETC.

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 license. This license 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: Edimar Louzada Date: 4/9/10

Print Name: EDIMAR LOUZADA Phone: 617-776-2011

FOR NEW APPLICANTS OR APPLICANTS CHANGING THEIR BUSINESS PLAN:

INSPECTIONAL SERVICES DEPARTMENT RECOMMENDATION:

The Inspectional Svcs. Dept. recommends that the application be: ☐ Approved ☐ Denied

Signature: _____ Date: _____

POLICE DEPARTMENT RECOMMENDATION:

The Chief of Police recommends that the application be: ☐ Approved ☐ Denied

Signature: _____ Date: _____

CONDITIONS

1. I certify that I am a citizen of the United States.
2. I will not primarily engage in the picking, sorting or storage of rags or waste papers.
3. I will not primarily engage in the use of a vehicle for the collection of junk, old metals, or other secondhand articles in the City.

4. _____

Signature of Applicant: Edimar Louzada Date: _____

**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.

Edimar Lourada

*Signature of Individual or Corporate Name (Mandatory)

By: Corporate Officer (Mandatory, if a corporation)

564-840-252

**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: SUNSHINE'S LUCY'S

Address of taxpayer/applicant's business in Somerville: 89-93 HOLLAND ST. SOMERVILLE

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

Taxpayer/applicant's phone: day: 617.726 2011 evening: 617.8958129

I, (print name) EDIMAR LOUZADA, 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 9th day of

APRIL, 20 10.
(Taxpayer's signature)

CITY'S ACKNOWLEDGEMENT

DATE OF ISSUANCE: _____ INCLUDES RELEVANT POSTINGS THROUGH: _____

TAXES AND ACCOUNT NUMBER(S) INCLUDED IN CERTIFICATE:

<input type="checkbox"/> Real Estate	<input type="checkbox"/> Water/Sewer	<input type="checkbox"/> Personal Property	<input type="checkbox"/> Other: _____
# <u>11350040</u>	# <u>326011001</u>	# _____	# _____

NOTES:

CLERK'S INITIALS: R

ORIGINAL STAMP:

received
4-22-10

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: SUNSHINE LUCY'S
Address: 93 HOLLAND ST.
City: SOMERVILLE State: MA Zip: 02144 Phone #: 617.776.2011

- | | |
|--|--|
| <input type="checkbox"/> I am an employer with _____ employees (full and/or part time). | Business Type: <input type="checkbox"/> Retail |
| <input checked="" type="checkbox"/> I am a sole proprietor or partnership and have no employees. | <input type="checkbox"/> Restaurant/Bar/Eating Establishment |
| <input type="checkbox"/> We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees. | <input type="checkbox"/> Office and/or Sales (real estate, auto, etc.) |
| <input type="checkbox"/> We are a nonprofit organization staffed by volunteers and have no employees. | <input type="checkbox"/> Nonprofit |
| | <input type="checkbox"/> Entertainment |
| | <input type="checkbox"/> Manufacturing |
| | <input type="checkbox"/> Health Care |
| | <input type="checkbox"/> Other _____ |

Workers' compensation insurance information (if applicable):

Insurance Company Name: _____
Address: _____
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.

Signature: Edimar Louzada Date: 4/9/10
Print Name: EDIMAR LOUZADA

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

City or Town: _____	Permit/License #: _____	<input type="checkbox"/> Board of Health
		<input type="checkbox"/> Building Department
		<input type="checkbox"/> City/Town Clerk
		<input type="checkbox"/> Licensing Board
		<input type="checkbox"/> Selectmen's Office
Contact Person: _____	Phone #: _____	<input type="checkbox"/> Other _____