

NOTE: COMPLETE FORM AND FORWARD WITH FEE TO CITY CLERK' OFFICE.
DO NOT RETURN FORM TO DEPARTMENT OF PUBLIC SAFETY.

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
11 HASTINGS ROAD
WINCHESTER MA 01890 4444
Lic#: F-2011-030
B.O.A.#: 149580
Fee: \$500.00

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: Trust: Agency Ship Gov't 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, 2011. The responsibility for filing on time is yours.

If the renewal application is not returned to the City Clerk's office by 04/30/2011 please advise this office at once.

This renewal application must be signed by the holder of the license.

Check One: Owner Occupant Holder

[Signature]
Signature of Applicant

11 HASTINGS RD.
Address

WINCHESTER MA 01890
City State Zip

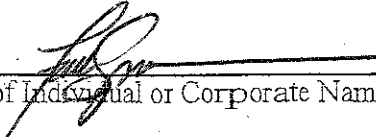
** Office Use Only **
Mailed
Taken
Received: _____
City Clerk

2011 APR 25 P 3:29
CITY CLERK'S OFFICE
SOMERVILLE, MA

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)

FRANK SPINOSA
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: 781-395-9679 evening: 617 212 9413

I, (print name) Frank Spivola, 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, 20 11. _____
(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: _____
18566143 # 302024011 # 32011167 # _____

NOTES:

CLERK'S INITIALS: UB

ORIGINAL STAMP:

 **RECEIVED**
UB
4-25-11



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: ADP TOTAL SOURCE

address: 10200 SUNSET DR.

city: MIAMI FL. phone #: 1-800-534-1802

insurance co. AON RISK SERVICES policy # WC 058 341072 MA

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 [Signature] Date 4/25/11

Print name FRANK SPINOSA Phone # 781 395-5629

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 _____



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YY)
06/13/10
Certificate ID: 210682

PRODUCER Aon Risk Services, Inc. of FL 1001 Brickell Bay Drive, Suite #1100 Miami, FL 33131-4937 Phone: 800-743-8130 Fax: 800-522-7514	THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW.	
	INSURERS AFFORDING COVERAGE	NAIC #
INSURED ADP TotalSource II, Inc. 10200 Sunset Drive Miami, FL 33173 ALTERNATE EMPLOYER Hillside Automotive Repair, In 583 Broadway Somerville, MA 02145	INSURER A: Illinois National Insurance Co	23817
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS. LIMITS SHOWN ARE AS REQUESTED.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YYYY)	POLICY EXPIRATION DATE (MM/DD/YYYY)	LIMITS	
	<input type="checkbox"/>	GENERAL LIABILITY <input type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC				EACH OCCURRENCE	\$
						DAMAGE TO RENTED PREMISES (Ea occurrence)	\$
						MED EXP (Any one person)	\$
						PERSONAL & ADV INJURY	\$
						GENERAL AGGREGATE	\$
						PRODUCTS - COMP/OP AGG	\$
							\$
	<input type="checkbox"/>	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRED AUTOS <input type="checkbox"/> NON OWNED AUTOS				COMBINED SINGLE LIMIT (Ea accident)	\$
						BODILY INJURY (Per person)	\$
						BODILY INJURY (Per accident)	\$
						PROPERTY DAMAGE (Per accident)	\$
	<input type="checkbox"/>	GARAGE LIABILITY <input type="checkbox"/> ANY AUTO				AUTO ONLY - EA ACCIDENT	\$
						OTHER THAN AUTO ONLY: EA ACC	\$
						AGG	\$
	<input type="checkbox"/>	EXCESS / UMBRELLA LIABILITY <input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS MADE <input type="checkbox"/> DEDUCTIBLE <input type="checkbox"/> RETENTION				EACH OCCURRENCE	\$
						AGGREGATE	\$
							\$
							\$
A		WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR / PARTNER / EXECUTIVE OFFICER/MEMBER EXCLUDED? <input type="checkbox"/> Y/N (Mandatory in NH) If Yes, describe under SPECIAL PROVISIONS below	WC 058341072 MA	07/01/10	07/01/11	<input checked="" type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER	
						E.L. EACH ACCIDENT	\$ \$2,000,000
						E.L. DISEASE - EA EMPLOYEE	\$ \$2,000,000
						E.L. DISEASE - POLICY LIMIT	\$ \$2,000,000
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS
 All worksite employees working for the above named client company, paid under ADP TOTALSOURCE, INC.'s payroll, are covered under the above stated policy. The above named client is an alternate employer under this policy.

CERTIFICATE HOLDER

HILLSIDE AUTOMOTIVE REPAIR, INC.
 583 BROADWAY
 SOMERVILLE, MA 02145

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING COMPANY WILL ENDEAVOR TO MAIL 30 DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

Aon Risk Services, Inc. of FL