



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

**APPLICATION TO RENEW TAXI MEDALLION LICENSE**

**SOMERVILLE TRANSPORTATION COMPANY INC**  
**PO BOX 1676**  
**WESTFORD, MA 01886**

License #: **427**

City #70

Fee: **250.00**

Account ID: **336**

Reference #: **427**

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: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> Business Location: <b>OUT OF AREA</b> Business Phone: <b>978-423-8775</b>	
License Holder: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> <b>PO BOX 1676</b> <b>WESTFORD, MA 01886</b> <b>978-423-8775</b>	
Mailing Address: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> <b>PO BOX 1676</b> <b>WESTFORD, MA 01886</b>	
Business Type: <b>CORPORATION (INC. LLC)</b> <b>PRESIDENT - JOHN DASILVA</b> <b>SECRETARY - JOHN DASILVA</b> <b>TREASURER - JOHN DASILVA</b>	
FID: <b>752992167</b>	
Food Manager/Emergency Contact: <b>JOHN DASILVA</b>	

2014 APR - 1 P 12:04  
CITY CLERK'S OFFICE  
SOMERVILLE, MA

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

Hours: **NOT APPLICABLE**

**MEDALLION #70**

Description of Location and/or Other Conditions:

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: \_\_\_\_\_

Date: 3/31/14

Print Name: JOHN DASILVA

Phone: 978-423-8775



**CITY OF SOMERVILLE  
BOARD OF ALDERMEN**  
93 HIGHLAND AVENUE  
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**APPLICATION TO RENEW TAXI MEDALLION LICENSE**

**SOMERVILLE TRANSPORTATION COMPANY INC**  
**PO BOX 1676**  
**WESTFORD, MA 01886**

License #: **428**  
City #71  
Fee: **250.00**  
Account ID: **336**  
Reference #: **428**

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: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> Business Location: <b>OUT OF AREA</b> Business Phone: <b>978-423-8775</b>	
License Holder: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> <b>PO BOX 1676</b> <b>WESTFORD, MA 01886</b> <b>978-423-8775</b>	
Mailing Address: <b>SOMERVILLE TRANSPORTATION COMPANY INC</b> <b>PO BOX 1676</b> <b>WESTFORD, MA 01886</b>	
Business Type: <b>CORPORATION (INC. LLC)</b> <b>PRESIDENT - JOHN DASILVA</b> <b>SECRETARY - JOHN DASILVA</b> <b>TREASURER - JOHN DASILVA</b>	
FID: <b>752992167</b>	
Food Manager/Emergency Contact: <b>JOHN DASILVA</b>	

2014 APR - 1 PM 12:04  
CITY CLERK'S OFFICE  
SOMERVILLE, MA

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

Hours: **NOT APPLICABLE**

**MEDALLION #71**

Description of Location and/or Other Conditions:

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: *John D. Silva*  
Print Name: JOHN DASILVA

Date: 3/31/14  
Phone: 978-423-8775

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

**Workers' Compensation Insurance Affidavit - General Business**

**Applicant information:**

Name: Somerville Trans Co Inc.

Address: PO Box 1676

City: Westford

State: Ma

Zip: 01886

Phone #: 978-423-8775

- ☐ I am an employer with \_\_\_\_\_ employees  
(full and/or part time).
- ☐ I am a sole proprietor or partnership and have no employees.
- ☒ We are a corporation that has exercised our right of exemption per c152 s1(4), and have no employees.
- ☐ We are a nonprofit organization staffed by volunteers and have no employees.

**Business Type:**

- ☐ Retail
- ☐ Restaurant/Bar/Eating Establishment
- ☐ Office and/or Sales (real estate, auto, etc.)
- ☐ Nonprofit
- ☐ Entertainment
- ☐ Manufacturing
- ☐ Health Care
- ☐ 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: \_\_\_\_\_

Date: 3/31/14

Print Name: John DaSilva

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

City or Town: \_\_\_\_\_ Permit/License #: \_\_\_\_\_

- ☐ Board of Health
- ☐ Building Department
- ☐ City/Town Clerk
- ☐ Licensing Board
- ☐ Selectmen's Office
- ☐ Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_