**CITY OF SOMERVILLE**
Commonwealth of Massachusetts
93 Highland Avenue
Somerville, MA 02143
(617) 625-6600



# Application to Renew Garage License

**PARTNERS HEALTHCARE SYSTEM, INC.**
**800 BOYLSTON STREET, SUITE 1150**
**BOSTON MA 02199**

**License #:** BL15-000945
**File #:** 15-749
**Fee:** 605

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:** PARTNERS HEALTHCARE SYSTEM INC.<br>**Business Location:** 21 THIRD AVE<br>**Business Phone:** 617-278-1037 | |
| **License Holder:** PARTNERS HEALTHCARE SYSTEM, INC.<br>800 BOYLSTON STREET, SUITE 1150<br>BOSTON MA 02199 | |
| **Mailing Address:** CBRE<br>65 LANDSDOWNE ST<br>CAMBRIDGE MA 02139 | |
| **Business Type:** Corporation<br>DAVID TORCHIANA<br>PETER MARKELL<br>MAUREEN GOGGIN | |
| **FID:** 043230035 | |
| **Emergency Contact:** REBECCA COBURN<br>**Phone:** 617-726-5400 | |
| **Proposed Hours of Operation if outside standared hours:** MO-FR 4AM-MIDNITE, SA 8AM-7PM<br>**# of Vehicles Kept Inside:** 76<br>**# of Vehicles Kept Outside:** 93<br>**Open to the public?** No<br>**Mechanical repairs?** Yes<br>**Autobody work?** No<br>**Spray Painting?** No<br>**Washing vehicles?** Yes<br>**Charging money to store vehicles?** Yes<br>**Storing unregistered vehicles?** No<br>**Maintaining or operating a tow vehicle at this location?** No | |

I hereby certify under the penalties of perjury that the following is true:

City of Somerville, Massachusetts
Finance Department, Treasury Division

## CERTIFICATE OF GOOD STANDING

Exact name of taxpayer/applicant's business: Partners HealthCare System, Inc.

Address of taxpayer/applicant's business in Somerville: 21 Third Avenue, Somerville, MA 02143

Address of taxpayer/applicant's home in Somerville: N/A

Taxpayer/applicant's phone: day: 617-724-5234 evening: 617-724-5234

I, (print name) Robin L. Berry, 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 31 day of March, 2016. Robin L. Berry
(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: ___

# 15087 # 551001042 # NA # ✓

**NOTES:**

**CLERK'S INITIALS:** _____ **ORIGINAL STAMP:**

received 4-20-16

*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: Partners HealthCare System, Inc.

Address: 800 Boylston Street, Suite 1150

City: Boston State: MA Zip: 02199 Phone #:

- [X] I am an employer with 60,000 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
- [X] Health Care (non-profit)
- [ ] Other

**Workers' compensation insurance information (if applicable):**

Insurance Company Name: Self-Insured; see attached DIA certificate

Address: 800 Boylston Street, Suite 1150

City: Boston State: MA Zip: 02199 Phone #:

Policy #: See attached DIA certificate 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: _____

Print Name: _____

***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 #:* _____

(revised Jan. 2008)

# The Commonwealth of Massachusetts

**License No.** 873

**Serial No.** 11880

**DEPARTMENT OF INDUSTRIAL ACCIDENTS**

**This is to Certify that** PARTNERS HEALTHCARE SYSTEM, INC. AND ITS' SUBSIDIARIES

*of* 529 Main Street, Charlestown, MA 02129, *having conformed with the provisions of sub-paragraph (* 2, b *) of Section 25A of Chapter 152 of the General Laws is hereby licensed to be a*

# SELF-INSURER

*This license is effective for a period of one year from the* FIRST *day of* SEPTEMBER *20*15*, at 12:01 A.M., unless sooner revoked.*

DEPARTMENT OF INDUSTRIAL ACCIDENTS

Linda E. Turner

DIRECTOR

THIS LICENSE MUST BE POSTED AT THE LOCATION OF THE BUSINESS