



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

2015 APR 20 P 3:30

CITY CLERK'S OFFICE
SOMERVILLE, MA

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

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 #:

- I am an employer with 40,000 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
 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 #: _____
Contact Person: _____ Phone #: _____

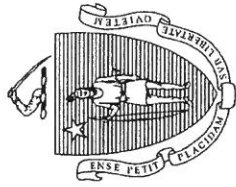
Board of Health
 Building Department
 City/Town Clerk
 Licensing Board
 Selectmen's Office
 Other _____

The Commonwealth of Massachusetts

DEPARTMENT OF INDUSTRIAL ACCIDENTS

License No.
873

Serial No. 11880



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 F I R S T day of

S E P T E M B E R 20 15, at 12:01 A.M., unless sooner revoked.

DEPARTMENT OF INDUSTRIAL ACCIDENTS

John E. ...
D I R E C T O R

THIS LICENSE MUST BE POSTED AT THE LOCATION OF THE BUSINESS