TOWN OF CONWAY, MASSACHUSETTS
BOARD OF HEALTH
5 Academy Hill Rd.
P. O. Box 240
Conway, Ma 01341
Phone: (413) 369-4235 Ext. 8
Fax: (413) 369-4237
Email: boardofhealth@conwayma.gov

# Application for Permit to Remove, Transport and Dispose of Garbage and Other Substances

**$100.00**

Date: _____

Applicant Name: _____

DBA: _____

Street Address: _____

Mailing Address: _____

Business Phone: _____ Residence Phone: _____

Applicant Signature: _____

If you will be hauling septage, please be advised that the Board of Health monitors volumes pumped from septic tanks to determine whether or not a system could be in failure. Please indicate the method that you will be using to determine the volume of septage pumped:

_____

_____

If you have not previously held a Hauler's Permit in the Town of Conway, please include copies of permits issued by other towns or otherwise demonstrate your experience and qualifications.

- You must indicate your arrangements for disposal site(s) above.
- You must complete the attached insurance affidavit.
- A system pumping record must be submitted to this office within 14 days of the pumping date.
- The Board of Health reserves the right to require copies of weigh slips.

The Board of Health will review this application and attachments at its next regularly scheduled Monday meeting. Please return your completed application, insurance affidavit and fee (payable to the Town of Conway) to:

Please return your completed application and fee (payable to the Town of Conway) to:

**Board of Health**
**P.O. Box 240**
**Conway, MA 01341**

**For Board of Health use:**

Permit Issued: Date _____ Permit Number _____

Permit Not Issued: Date _____ Reason _____

*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- 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.
☐ I am an employer with _____ employees (full & part time).

**Business Type:** ☐ Retail ☐ Restaurant/Bar/Eating Establishment ☐ Office ☐ Sales (including Real Estate, Autos etc.) ☐ Other _____

☐ I am an employer providing workers' compensation for my employees working on this job.

company name: _____

address: _____

city: _____ phone #: _____

insurance co. _____ policy # _____

☐ I am a sole proprietor and have hired the independent contractors listed below who have the following workers' compensation polices:

company name: _____

address: _____

city: _____ phone #: _____

insurance co. _____ policy # _____

company name: _____

address: _____

city: _____ phone #: _____

insurance co. _____ policy # _____

Attach additional sheets 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 _____ Date _____

Print name _____ Phone # _____

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 _____