

License # \_\_\_\_\_

Check # \_\_\_\_\_

**THE COMMONWEALTH OF MASSACHUSETTS**  
**TOWN OF NORTON**  
**BOARD OF HEALTH**

**Application to Perform Title 5 Services**

*This form must be completely filled out leaving no blanks*

Name: \_\_\_\_\_  
First Middle Int. Last

Address: \_\_\_\_\_  
No. Street Town State Zip

Phone: ( ) Cell: ( )

Business Name: \_\_\_\_\_

Business Address: \_\_\_\_\_  
No. Street City State Zip

Mailing Address: \_\_\_\_\_  
No. Street City State Zip

Social Security # or FEIN # \_\_\_\_\_

**Type of Registration(s)**

|                          |       |          |     |
|--------------------------|-------|----------|-----|
| Engineer / Sanitarian    | _____ | \$75.00  | Fee |
| Soil Evaluator           | _____ | \$75.00  | Fee |
| Title 5 System Inspector | _____ | \$75.00  | Fee |
| Title 5 System Test      | _____ | \$50.00  | Fee |
| Title 5 Installer        | _____ | \$125.00 | Fee |

Are you familiar with recent revisions to Title 5? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you familiar with the Norton Board of Health Regulations and the addendum to Title 5?

Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a hydraulic license? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes hydraulic license number and copy required. \_\_\_\_\_

\*\*\*Would you like your name to be put on a list for people seeking services in your field?

Yes \_\_\_\_\_ No \_\_\_\_\_

\*\*\*A copy of current applicable State Certification(s) will be required with this application.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



The Commonwealth of Massachusetts  
Department of Industrial Accidents  
Office of Investigations  
600 Washington Street  
Boston, MA 02111  
[www.mass.gov/dia](http://www.mass.gov/dia)

Workers' Compensation Insurance Affidavit: General Businesses

**Applicant Information**

Please Print Legibly

Business/Organization Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

1. ☐ I am an employer with \_\_\_\_\_ employees (full and/or part-time).\*
2. ☐ I am a sole proprietor or partnership and have no employees working for me in any capacity.  
[No workers' comp. insurance required]
3. ☐ We are a corporation and its officers have exercised their right of exemption per c. 152, §1(4), and we have no employees. [No workers' comp. insurance required]\*\*
4. ☐ We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]

**Business Type (required):**

5. ☐ Retail
6. ☐ Restaurant/Bar/Eating Establishment
7. ☐ Office and/or Sales (incl. real estate, auto, etc.)
8. ☐ Non-profit
9. ☐ Entertainment
10. ☐ Manufacturing
11. ☐ Health Care
12. ☐ Other \_\_\_\_\_

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.

\*\*If the corporate officers have exempted themselves, but the corporation has other employees, a workers' compensation policy is required and such an organization should check box #1.

*I am an employer that is providing workers' compensation insurance for my employees. Below is the policy information.*

Insurance Company Name: \_\_\_\_\_

Insurer's Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Policy # or Self-ins. Lic. # \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Attach a copy of the workers' compensation policy declaration page (showing the policy number and expiration date).

Failure to secure coverage as required under Section 25A of MGL c. 152 can lead to the imposition of criminal penalties of a fine up to \$1,500.00 and/or one-year imprisonment, as well as civil penalties in the form of a STOP WORK ORDER and a fine of up to \$250.00 a day against the violator. Be advised that a copy of this statement may be forwarded to the Office of Investigations of the DIA for insurance coverage verification.

*I do hereby certify, under the pains and penalties of perjury that the information provided above is true and correct.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Phone #: \_\_\_\_\_

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

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

Issuing Authority (circle one):

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Licensing Board 5. Selectmen's Office  
6. Other \_\_\_\_\_

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