

COMMON VICTUALLERS' LICENSE

This license is for seating in restaurants or any other establishment which serves food to be eaten on the premises:

APPLICANT INSTRUCTIONS:

1. Contact Zoning Enforcement Officer (Building Dept.) for approval of location and seating (numbers).
2. Contact Board of Health to comply with all local and state regulations. Once Board of health has performed final inspection and so advised, we can proceed.
3. Application should be filled out requesting Common Victualler's License. There is a fee of \$75.00 required. Please provide a check in that amount payable to the Town of Canton. Once final inspection results are received, the license may be scheduled for the Board of Selectmen's meeting. Board of Selectmen signs license which is issued to applicant the following day. The applicant is required to renew this license well in advance of its expiration date each year of December 31st.

7-12-07

Commonwealth of Massachusetts

TOWN OF CANTON

Application for a Common Victualler's Special Permit

Date of Application: _____

In accordance with the provisions of the State Statutes relating thereto, application for a Common Victualler's Special Permit is hereby made by:

BUSINESS NAME:

(Full name of person, firm or corporation making application)

BUSINESS ADDRESS:

BUSINESS TELEPHONE NUMBER:. _____

FEE: \$75.00 – Payable to the Town of Canton

Signature of applicant

Print Name and title of applicant

Home Address _____

Phone Number (Home or cell) _____

(updated 7-12-07)

DATE:

Board of Selectmen/Licensing Authority
Memorial Hall
801 Washington Street
Canton, MA 02021

Board of Selectmen:

Pursuant to Mass. General Laws, Chapter 62C, Section 49A, I/we hereby certify, under the penalties of perjury, that I/we, to the best to my knowledge and belief, have filed all state tax returns and paid all state and local taxes required under the law.

Business or Corporate Name: _____

**Signature of Individual
or Corporate Officer (Mandatory*)** _____

Address (Number & Street) _____

City, State, Zip Code _____

Social Security Number or
Federal Identification Number _____

* This license will not be issued unless this certification clause is signed by the applicant.

Your social security number of federal identification number will be furnished to the Mass. Department of Revenue to determine whether you have met tax filling and tax payment obligations. Licensees who fail to correct their non-filings or delinquency will be subject to license suspension or revocation. This request is made under the authority of Mass. General Laws, Chapter 62, Section 49A.



The Commonwealth of Massachusetts
 Department of Industrial Accidents
 Office of Investigations
 600 Washington Street
 Boston, MA 02111
 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 #: _____