



BOARD OF HEALTH  
**TOWN OF FOXBOROUGH**  
 MASSACHUSETTS 02035

www.foxboroughma.gov

40 SOUTH STREET  
 Tel. (508) 543-1207  
 Fax (508) 543-6278

**APPLICATION FOR: Residential, Municipal, and Commercial Solid Waste Hauler**  
 new January 2016

Application must be submitted 30 days before renewal date to avoid the late fee.

\$100.00 each trash truck/roll-off truck

Include \$200 LATE FEE IF submitted less than 30 days before renewal date.

BHP - \_\_\_\_\_  
 CHECK #: \_\_\_\_\_  
 DATE REC'D: \_\_\_\_\_

NO REFUNDS OR TRANSFER OF FUNDS

Company Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

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

Mailing Address (if different): \_\_\_\_\_

Name of Owner/Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address of Owner/Contact Person: \_\_\_\_\_

Person in Charge \_\_\_\_\_ Cell phone: \_\_\_\_\_ Email \_\_\_\_\_

Back-up emergency Contact \_\_\_\_\_ Cell phone \_\_\_\_\_ Email \_\_\_\_\_

We hereby make application for a permit to engage in the business of collecting residential, municipal, and/or commercial solid waste (and recyclables) in the Town of Foxborough.

Vehicle #1 Make: \_\_\_\_\_ Model: \_\_\_\_\_ License Plate: \_\_\_\_\_  
 Truck Identification Number: \_\_\_\_\_ Capacity/Size: \_\_\_\_\_

Vehicle #2 Make: \_\_\_\_\_ Model: \_\_\_\_\_ License Plate: \_\_\_\_\_  
 Truck Identification Number: \_\_\_\_\_ Capacity/Size: \_\_\_\_\_

Vehicle #3 Make: \_\_\_\_\_ Model: \_\_\_\_\_ License Plate: \_\_\_\_\_  
 Truck Identification Number: \_\_\_\_\_ Capacity/Size: \_\_\_\_\_

\*\*\* List additional vehicles on a separate attached sheet \*\*\*

**Additional Required Information:**

1. Where is your **Primary** disposal location for solid waste? \_\_\_\_\_

**Secondary** disposal location for solid waste? \_\_\_\_\_

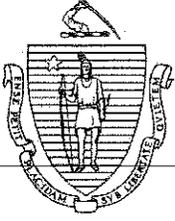
2. Where is your **Primary** disposal location for recyclables? \_\_\_\_\_

**Secondary** disposal location for recyclables? \_\_\_\_\_

3. List all other disposal sites used for other materials collected (yard waste, C&D, etc):

Material: \_\_\_\_\_ Disposal Location: \_\_\_\_\_





The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 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 #: \_\_\_\_\_