

# Debris Disposal Affidavit

DEMOLITION SITE ADDRESS \_\_\_\_\_  
DISPOSAL/DUMPSTER FIRM \_\_\_\_\_  
APPLICANT'S SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_

## Workers Compensation Affidavit

Name (Business/Organization/Individual): \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_

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. I am a homeowner doing all work myself. [No workers' comp. insurance required.]\*
4. I am a homeowner and will be hiring contractors to conduct all work on my property. I will ensure that all contractors either have workers' compensation insurance or are sole proprietors with no employees.
5. I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have employees and have workers' comp. insurance.†
6. We are a corporation and its officers have exercised their right of exemption per MGL c. 152, §1(4), and we have no employees. [No workers' comp. insurance required.]

Type of Project (Required):

7. New Construction
8. Remodeling
9. Demolition
10. Building Addition
11. Electrical Work
12. Plumbing Work
13. Roof Work
14. Other:

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

† Homeowners who submit this affidavit indicating they are doing all work and then hire outside contractors must submit a new affidavit indicating such  
‡ Contractors that check this box must attached an additional sheet showing the name of the sub-contractors and state whether or not those entities have employees. If the sub-contractors have employees, they must provide their workers' comp. policy number.

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

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

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

Job Site Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

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

Failure to secure coverage as required under MGL c. 152, §25A is a criminal violation punishable by 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. 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

1. Board of Health 2. Building Department 3. City/Town Clerk 4. Electrical Inspector 5. Plumbing Inspector

6. Other \_\_\_\_\_

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