



## Town of Oak Bluffs Business License Application

Map \_\_\_\_ Lot \_\_\_\_

This Form must be complete to avoid processing Delays. Please return to Selectmen's office.

Business Name: _____	Physical Address: _____
Applicant Name: _____	Mailing Address: _____
Applicant Phone: hm _____ cell _____ email _____	
Owner of Business: _____	Mailing Address: _____
Owner Phone: hm _____ cell _____ email _____	
<b>Applicant Signature:</b> _____	<b>Date:</b> _____ SS# or FEIN _____

**Type of License:** Annual \_\_\_\_ Seasonal \_\_\_\_ **Dates Open:** From: \_\_\_\_ To: \_\_\_\_

Alcohol Consumed on Premises:	New ____ Renewal ____ #Seats ____ #Entrance ____ # Exits ____
Alcohol not Consumed on Premises:	New ____ Renewal ____ #Entrance ____ # Exits ____
Common Victualler :	New ____ Renewal ____ #Seats ____ #Entrance ____ # Exits ____
General Retail:	New ____ Renewal ____ #Entrance ____ # Exits ____
Inn Holder/ Lodging:	New ____ Renewal ____ #Rooms ____ #Entrance ____ # Exits ____
Transient Vender:	New ____ Renewal ____ other (Explain) _____
Taxi Business:	New ____ Renewal ____ other (Explain) _____ Number of Vehicles to be licensed _____ Address where vehicles will be stored _____
Livery Business:	New ____ Renewal ____ other (Explain) _____ Number of Vehicles to be licensed _____ Address where vehicles will be stored _____
Auto Business:	New ____ Renewal ____ other (Explain) _____ Number of Auto vehicles to be licensed _____
Other Business:	Specify _____

Has anything changed from last year including Floor Plan, Management, Occupancy, Seats, etc.? \_\_\_\_\_

If so, please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please see the following departments for their sign offs, which you will need before the Selectmen can issue your business license.

**Required Sign Offs**

Town Clerk: _____	Date: _____
Tax Collector: _____	Date: _____
Wastewater 1: _____	Date: _____
Wastewater 2: _____	Date: _____

*\*Tax department can sign for Wastewater 1 \*Wastewater 2 necessary for new businesses and/or change of premise*

Reminder to see Building Department, Board of Health, and Fire Department for other required permits, fees, and inspections.

**Office Use Only :**

Application Received Date: \_\_\_\_\_

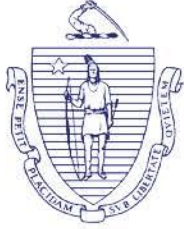
Board of Selectmen Approval Date: \_\_\_\_\_

Fees Paid: check/cash \_\_\_\_\_ Date: \_\_\_\_\_

Certificate of State Tax Compliance: \_\_\_\_\_ Yes \_\_\_\_\_ No

Workers Compensation Insurance: \_\_\_\_\_ Yes \_\_\_\_\_ No

ABCC renewal form if applicable: \_\_\_\_\_ Yes \_\_\_\_\_ No



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 Lafayette City Center  
 2 Avenue de Lafayette, Boston, MA 02111-1750  
 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 a 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 § 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 (check one):**

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

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

