Town of Oak Bluffs
Business License Application

Map ____ Lot ____

This Form must be complete to avoid processing Delays. Please return to Selectmenôs office.

Business Name: _____ Physical Address: _____

Applicant Name: _____ Mailing Address: _____
Applicant Phone:
hm_____cell_____email_____

Owner of Business: _____ Mailing Address: _____
Owner Phone:
hm_____cell_____email_____

Applicant Signature: _____ **Date:** _____ 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'll 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 #:**_____

Certification of State Tax Compliance

I, _____, certify under the penalties of perjury that I, to the
Print Name
best of my knowledge and belief have filed and paid all state tax returns and taxes required under the Massachusetts State Law.

_____ _____

Signature of Individual or Corporate Name *(Required)** By: Corporate Officer (Required if Applicable)

_____

Social Security Number (Voluntary) or F I D Number **

*** License will not be issued unless certification clause is signed by the applicant.**

**** Your Social Security Number will be furnished to the Massachusetts Department of Revenue for determination of tax filing or tax payment obligations. Licensee's who fail to correct their non-filing or delinquency will be subject to license suspension or revocation. This request is made under the authority of the Massachusetts General Laws, Chapter 62C, Section 49A.**

Additional Informaton:_____