



# CITY OF LYNN

INSPECTIONAL SERVICES DEPARTMENT

Room 401, Lynn City Hall, Lynn, Massachusetts 01901 Tel: (781) 598-4000

## MECHANICAL PERMIT APPLICATION

Date: \_\_\_\_\_ Owner's Name: \_\_\_\_\_

Building location: \_\_\_\_\_ Type of occupancy: \_\_\_\_\_

Installing company name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Business phone: \_\_\_\_\_ License type: \_\_\_\_\_

Name of Licensee: \_\_\_\_\_ License #: \_\_\_\_\_

Signature of licensee: \_\_\_\_\_

Mechanical	Furnaces	Central A/C	Gas/Oil burner	Methane pump	External grease	Restaurant kitchen	Baseboard heat	Oil tanks	Heat pumps	Rooftop units	Generators	Air handling units	Evaporator coils
Basement													
1 <sup>st</sup> floor													
2 <sup>nd</sup> floor													
3 <sup>rd</sup> floor													

### INSURANCE COVERAGE

I have a current liability insurance policy or its substantial equivalent which meets the requirements of MGL CH 142

Yes  No

If you have checked yes, please indicate the type of coverage by checking the appropriate box below

A liability insurance policy  Bond  Other type of indemnity

OWNERS INSURANCE WAIVER: I am aware that the licensee does not have the insurance coverage required by Chapter 142 of the Mass General Laws, and that my signature on this permit application waives this requirement check.

Signature of owner or owner's agent \_\_\_\_\_

Owner  Agent

ESTIMATED COST OF JOB \_\_\_\_\_



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 1 Congress Street, Suite 100  
 Boston, MA 02114-2017  
 www.mass.gov/dia

Print Form

**Workers' Compensation Insurance Affidavit: Builders/Contractors/Electricians/Plumbers**  
**Applicant Information** **Please Print Legibly**

Name (Business/Organization/Individual): \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

<b>Are you an employer? Check the appropriate box:</b>		<b>Type of project (required):</b>
1. <input type="checkbox"/> I am an employer with _____ employees (full and/or part-time).*	4. <input type="checkbox"/> 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. <input type="checkbox"/> New construction
2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required.]	5. <input type="checkbox"/> 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.]	7. <input type="checkbox"/> Remodeling
3. <input type="checkbox"/> I am a homeowner doing all work myself. [No workers' comp. insurance required.] †		8. <input type="checkbox"/> Demolition
		9. <input type="checkbox"/> Building addition
		10. <input type="checkbox"/> Electrical repairs or additions
		11. <input type="checkbox"/> Plumbing repairs or additions
		12. <input type="checkbox"/> Roof repairs
		13. <input type="checkbox"/> 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 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. Electrical Inspector 5. Plumbing Inspector  
 6. Other \_\_\_\_\_

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