



MASSACHUSETTS UNIFORM APPLICATION FOR A PERMIT TO PERFORM PLUMBING WORK

P
TYPE OR PRINT CLEARLY

CITY MA DATE PERMIT #
JOBSITE ADDRESS OWNER'S NAME
OWNER ADDRESS TEL FAX
OCCUPANCY TYPE COMMERCIAL EDUCATIONAL RESIDENTIAL
NEW: RENOVATION: REPLACEMENT: PLANS SUBMITTED: YES NO

Table with columns: FIXTURES, FLOOR, BSM, 1-14. Rows include: BATHTUB, CROSS CONNECTION DEVICE, DEDICATED SPECIAL WASTE SYSTEM, DEDICATED GAS/OIL/SAND SYSTEM, DEDICATED GREASE SYSTEM, DEDICATED GRAY WATER SYSTEM, DEDICATED WATER RECYCLE SYSTEM, DISHWASHER, DRINKING FOUNTAIN, FOOD DISPOSER, FLOOR / AREA DRAIN, INTERCEPTOR (INTERIOR), KITCHEN SINK, LAVATORY, ROOF DRAIN, SHOWER STALL, SERVICE / MOP SINK, TOILET, URINAL, WASHING MACHINE CONNECTION, WATER HEATER ALL TYPES, WATER PIPING, OTHER.

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 CHECKED YES, PLEASE INDICATE THE TYPE OF COVERAGE BY CHECKING THE APPROPRIATE BOX BELOW

LIABILITY INSURANCE POLICY OTHER TYPE OF INDEMNITY BOND

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

CHECK ONE ONLY: OWNER AGENT

SIGNATURE OF OWNER OR AGENT

I hereby certify that all of the details and information I have submitted or entered regarding this application are true and accurate to the best of my knowledge and that all plumbing work and installations performed under the permit issued for this application will be in compliance with all Pertinent provision of the Massachusetts State Plumbing Code and Chapter 142 of the General Laws.

PLUMBER'S NAME LICENSE # SIGNATURE
MP JP CORPORATION # PARTNERSHIP # LLC #
COMPANY NAME ADDRESS
CITY STATE ZIP TEL
FAX CELL EMAIL



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 #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- |  |   |
|--|---|
| <p>1. <input type="checkbox"/> I am an employer with _____ employees (full and/or part-time).*</p> <p>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.]</p> <p>3. <input type="checkbox"/> I am a homeowner doing all work myself. [No workers' comp. insurance required.] †</p> | <p>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. ‡</p> <p>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.]</p> |
|--|---|

**Type of project (required):**

6.  New construction
7.  Remodeling
8.  Demolition
9.  Building addition
10.  Electrical repairs or additions
11.  Plumbing repairs or additions
12.  Roof repairs
13.  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 #: \_\_\_\_\_