



Town of Hatfield Board of Health

59 Main St.
Hatfield, MA 01038
Ph. (413) 247-9200 ext. 6
Fax. (413) 247-5029

FEE: \$100.00

Commonwealth of Massachusetts APPLICATION FOR A WELL PERMIT

WELL LOCATION: _____

APPLICANT NAME: _____

ADDRESS
(IF DIFFERENT): _____

TELEPHONE NUMBER: () _____ - _____

INFORMATION ABOUT THE PROPOSED WELL:

TYPE OF WELL

- ☐ DRILLED (ARTESIAN)
☐ DUG (SHALLOW)
☐ DRIVEN POINT
☐ OTHER (SPECIFY) _____

INTENDED USE: _____

WELL DRILLER: _____

LICENSE NO. _____
(NOTE: WELL DRILLER MUST BE REGISTERED BY MASSACHUSETTS)

DRILLER ADDRESS: _____
Street Town/City Zip

LOT LOCATION (ASSESSOR'S DESCRIPTION) SECTION_____ BLOCK____ LOT____

DRILLER'S TELEPHONE NO. ()____-____

I HEREBY APPLY FOR A WELL PERMIT. I AGREE TO COMPLY WITH THE HATFIELD BOARD OF HEALTH DEPARTMENT RULES AND REGULATIONS FOR THE REGISTRATION AND CONSTRUCTION OF PRIVATE WATER SUPPLIES (WELLS). I UNDERSTAND THAT THE FOLLOWING ARE REQUIRED:

- THE WELL DRILLER MUST BE REGISTERED WITH THE MASSACHUSETTS WATER RESOURCES COMMISSION AS REQUIRED BY CHAPTER 21, SECTION 16 MGL.
- A PLAN OF THE PROPOSED LOCATION OF THE WELL SHALL BE SUBMITTED TO THE HEALTH DEPARTMENT PRIOR TO THE INSTALLATION OF A WELL. THIS PLAN SHALL BE ON A SCALE OF APPROXIMATELY ONE INCH TO FORTY FEET AND SHALL SHOW POSSIBLE SOURCES OF CONTAMINATION ALONG WITH LOT LINES AND STRUCTURES ON THE LOT.
- CONSTRUCTION OF THE WELL SHALL NOT PROCEED UNTIL A WELL PERMIT HAS BEEN ISSUED BY THE HATFIELD BOARD OF HEALTH DEPARTMENT.
- WELL WATER NOT USED AS A POTABLE WATER SUPPLY SHALL NOT BE PLUMBED INTO ANY BUILDING SERVED BY THE HATFIELD WATER SUPPLY.
- ANNUAL WATER TESTING MUST BE CONDUCTED AND GIVEN TO THE HATFIELD BOARD OF HEALTH

THE ISSURANCE OF A WELL PERMIT SHALL NOT BE CONSTRUED AS A GUARANTEE BY THE HATFIELD BOARD OF HEALTH DEPARTMENT OR ITS AGENTS THAT THE WATER SYSTEM WILL FUNCTION SATISFACTORILY NOR THAT THE WATER SUPPLY SHALL BE SUFFICIENT IN QUALITY OR QUANTITY FOR ITS INTENDED USE.

PURSUANT TO MGL CH 62C, SEC. 49A, I CERTIFY THAT UNDER THE PENALTIES OF PERJURY THAT I, TO MY BEST KNOWLEDGE AND BELIEF, HAVE FILED ALL STATE TAX RETURNS AND PAID ALL STATE TAXES REQUIRED UNDER LAW.

DATE

SIGNATURE

SOCIAL SECURITY #

OR

NAME OF CORPORATION (IF APPLICABLE) FEDERAL ID NUMBER

PLEASE REMIT A CHECK FOR \$_____ MADE PAYABLE TO: THE TOWN OF HATFIELD FOR A WELL PERMIT. THANK YOU.

MASSACHUSETTS DEPARTMENT OF REVENUE
ENFORCEMENT AND PROTECTION (REAP) ATTESTATION

TOWN OF HATEFIELD
MASSACHUSETTS

I hereby declare under the penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

*Signature of individual or Corporate Names (Mandatory)

By: Corporate Officer (Mandatory, if applicable)

** Social Security Number or Federal Identification Number

* This license will not be issued unless this certification clause is signed by the applicant.

***Your Social Security Number will be furnished to the Massachusetts Department of Revenue to determine whether you have met tax filing or tax payment obligations. Licensees 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 M.G.L. Chapter 62C, Section 49A.



The Commonwealth of Massachusetts
Department of Industrial Accidents

1 Congress Street, Suite 100

Boston, MA 02114-2017

www.mass.gov/dia

Workers' Compensation Insurance Affidavit General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

Please Print Legibly

Applicant Information

Business/Organization Name: _____

Address: _____

City/State/Zip: _____ Phone #: _____

<p>Are you an employer? Check the appropriate box:</p> <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"/> 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]**</p> <p>4. <input type="checkbox"/> We are a non-profit organization, staffed by volunteers, with no employees. [No workers' comp. insurance req.]</p>	<p>Business Type (required):</p> <p>5. <input type="checkbox"/> Retail</p> <p>6. <input type="checkbox"/> Restaurant/Bar/Bathing Establishment</p> <p>7. <input type="checkbox"/> Office and/or Sales (incl. real estate, auto, etc.)</p> <p>8. <input type="checkbox"/> Non-profit</p> <p>9. <input type="checkbox"/> Entertainment</p> <p>10. <input type="checkbox"/> Manufacturing</p> <p>11. <input type="checkbox"/> Health Care</p> <p>12. <input type="checkbox"/> Other _____</p>
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*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 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. Licensing Board 5. Selectmen's Office
6. Other _____

Contact Person: _____ Phone #: _____

www.mass.gov/dia

Information and Instructions

Massachusetts General Laws chapter 152 requires all employers to provide workers' compensation for their employees. Pursuant to this statute, an *employee* is defined as "...every person in the service of another under any contract of hire, express or implied, oral or written."

An *employer* is defined as "an individual, partnership, association, corporation or other legal entity, or any two or more of the foregoing engaged in a joint enterprise, and including the legal representatives of a deceased employer, or the receiver or trustee of an individual, partnership, association or other legal entity, employing employees. However, the owner of a dwelling house having not more than three apartments and who resides therein, or the occupant of the dwelling house of another who employs persons to do maintenance, construction or repair work on such dwelling house or on the grounds or building appurtenant thereto shall not because of such employment be deemed to be an employer."

MGL chapter 152, §25C(6) also states that "every state or local licensing agency shall withhold the issuance or renewal of a license or permit to operate a business or to construct buildings in the commonwealth for any applicant who has not produced acceptable evidence of compliance with the insurance coverage required." Additionally, MGL chapter 152, §25C(7) states "Neither the commonwealth nor any of its political subdivisions shall enter into any contract for the performance of public work until acceptable evidence of compliance with the insurance requirements of this chapter have been presented to the contracting authority."

Applicants

Please fill out the workers' compensation affidavit completely, by checking the boxes that apply to your situation and, if necessary, supply your insurance company's name, address and phone number along with a certificate of insurance. Limited Liability Companies (LLC) or Limited Liability Partnerships (LLP) with no employees other than the members or partners, are not required to carry workers' compensation insurance. If an LLC or LLP does have employees, a policy is required. Be advised that this affidavit may be submitted to the Department of Industrial Accidents for confirmation of insurance coverage. Also be sure to sign and date the affidavit. The affidavit should be returned to the city or town that the application for the permit or license is being requested, not the Department of Industrial Accidents. Should you have any questions regarding the law or if you are required to obtain a workers' compensation policy, please call the Department at the number listed below. Self-insured companies should enter their self-insurance license number on the appropriate line.

City or Town Officials

Please be sure that the affidavit is complete and printed legibly. The Department has provided a space at the bottom of the affidavit for you to fill out in the event the Office of Investigations has to contact you regarding the applicant. Please be sure to fill in the permit/license number which will be used as a reference number. In addition, an applicant that must submit multiple permit/license applications in any given year, need only submit one affidavit indicating current policy information (if necessary). A copy of the affidavit that has been officially stamped or marked by the city or town may be provided to the applicant as proof that a valid affidavit is on file for future permits or licenses. A new affidavit must be filled out each year. Where a home owner or citizen is obtaining a license or permit not related to any business or commercial venture (i.e. a dog license or permit to burn leaves etc.) said person is NOT required to complete this affidavit.

The Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street
Boston, MA 02114-2017
Tel. # 617-727-4900 ext. 7406 or 1-877-MASSAIRE
Fax # 617-727-7749
www.mass.gov/dia