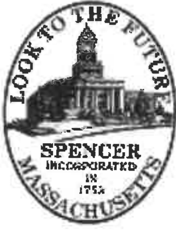


TOWN OF SPENCER, MASSACHUSETTS
CHECKLIST FOR APPLICATION FOR
AUTOMATIC AMUSEMENT DEVICE LICENSE

Automatic Amusement Device License

1. Check with Building Inspector to verify zoning compliance.
2. Submit the following paperwork to the Board of Selectmen's office:
   - Zoning compliance verification signed by Building Inspector.
   - Application.
   - Proof of control of premises (deed or lease).
   - Tax and insurance attestation.
   - Workers' compensation affidavit.
   - Workers' compensation insurance certificate.
3. Hearing will be scheduled at Board of Selectmen's meeting.
4. If approved, license will be granted when license fee ($30 per device) is paid.

Zoning Compliance Verification

Date of application: ______________________________

Name of establishment to be licensed: ______________________________

Address of establishment to be licensed: ______________________________

Type of license(s) being applied for: ______________________________

____

Type of use: ______________________________

____

____

To be filled out by the Inspector of Buildings/Zoning Enforcement Officer

Zoning District:

Use permitted: ☐Yes

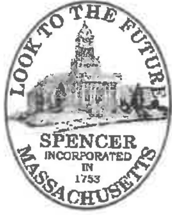
☐No

☐Special Permit required from ZBA

Comments/restrictions:

Signature:

Date:



TOWN OF SPENCER, MASSACHUSETTS
APPLICATION FOR
AUTOMATIC AMUSEMENT DEVICE LICENSE

Name of applicant: ______________________________

Address of applicant: ______________________________

Phone number of applicant: ______________________________

Premises where device(s) will be kept: ______________________________

FID or SSN: ______________________________

Type and make of automatic amusement device(s): ______________________________

____

____

____

Licenses expire December 31 of each year. If device is replaced or substituted during the term of the license, the device must be of the same type as described in the original license in order to be covered under the same license.

Board of Selectmen Approval:

Remarks:

Please submit this form to the Board of Selectmen, 157 Main Street, Spencer, MA 01562

TAX & INSURANCE ATTESTATION

A. Pursuant to M.G.L. Cg. 62C, Sec. 49A, I certify 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.

B. Pursuant to M.G.L. Ch. 40, Sec. 57, accepted by the Town of Spencer June 22, 1990, I certify under the penalties of perjury that I, to the best of my knowledge and belief, have paid all local taxes, fees, assessments, betterments or other municipal charges.

C. Pursuant to M.G.L. Ch. 152, Sec. 25C, subsection (6), I certify that I now have in effect a valid policy of insurance for Worker's Compensation covering all employees of the business to which this license is issued.

____
*Social Security Number

OR

____
*Federal Identification Number

____
**Signature of Individual or Corporate Name

By: ______________________________
Corporate Officer (if applicable)

Date ______________________________

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

* Your social security number or FID will be furnished to the Mass. Dept. 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 Mass. General Law, Ch. 62C, Sec. 49A.

Name of Business ______________________________

Address ______________________________

Name of Owner ______________________________
(Please print or type)

Tel. Number: Business ______________________ Home ______________________

Mailing Address ______________________________
(If different from above)

IMPORTANT NOTICE TO LICENSEES

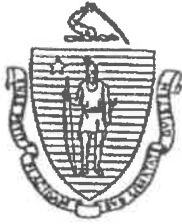
Pursuant to M.G.L. Chapter 152, Sec. 25A all employers conducting business in the Commonwealth of Massachusetts must carry a valid workers' compensation policy at all times. Please be advised that no business may be issued a license or permit without providing proof of worker's compensation coverage.

All Applicants/licensees must fill out the workers' compensation affidavit enclosed completely, checking the box which fits your situation. Please be sure to fill in insurance company name, address and phone number.

A copy of your certificate of insurance must be attached.

All parties must sign and date the affidavit.

Please return to the Board of Selectmen's Office



The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
600 Washington Street
Boston, MA 02111
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 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 #:** ______________________

Please return to the Board of Selectmen's Office