



TOWN OF MEDWAY
COMMONWEALTH OF MASSACHUSETTS

*Medway Town Hall
155 Village Street
Medway, MA 02053
Phone (508) 533-3206*

BOARD OF HEALTH

Bodywork Establishment Permit Application

Date: _____

Type of Application: ☐ New ☐ Renewal

Bodywork Establishment Information:

Establishment Name: _____

Address: _____, Medway, MA 02053

Mailing Address (if different): _____

Phone Number: _____ Email: _____

Applicant Information:

Name: _____

Mailing Address: _____

Phone Number: _____ Email: _____

Owner Information (all persons who have an ownership interest in the Establishment):

Name: _____

Address: _____

Phone Number: _____ Email: _____

****If there is more than one owner, then submit the above information for all owners- attach a separate document if necessary.

Do you own, operate, or are you an employee of any other Bodywork establishment located in Medway or elsewhere, ☐ Yes ☐ No

If yes, please disclose, the name, address, and telephone number of said establishment(s):

In addition, you must disclose the circumstances surrounding any of the following convictions or license/permit revocations:

- a. Any conviction for any sexual-related offence, including prostitution or sexual misconduct, rape or any other felony.
- b. Any conviction of any misdemeanor or felony.
- c. Revocation, suspension or denial of a permit or license to practice bodywork or massage issued by any state or municipality.
- d. Loss or restriction of a permit, license or certification by any municipality or other jurisdiction for any reason.

If any of the above are applicable, please explain the circumstances:

Please list all bodywork therapists expected to be working at the Establishment:

Name	Address	Phone Number

Hours of Operation:

Sun _____ Mon _____ Tue _____ Wed _____ Thu _____ Fri _____ Sat _____

Statement: I, _____, under penalty of perjury declare that the foregoing information contained in this application is true and correct. I affirm to comply with all rules and requirements of Medway's Board of Health. I understand that false statements shall constitute grounds for denial. Pursuant to M.G.L. Ch. 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.

Name (Please Print)

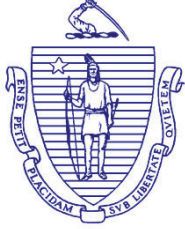
Signature

This section of the application is to be notarized for the above declaration.

Applications will not be accepted unless ALL of the following documents are enclosed with the application:

- Completed Bodywork Establishment Permit Application. Incomplete applications and missing documents may delay the review and permitting process.
- Permit Fee - \$200.00 - Make check payable to "Town of Medway" (non-refundable)
- Workman's Compensation Affidavit (*we have attached for you*)
- Certificate of Liability Insurance, (must have professional liability insurance of at least one million dollars (\$1,000,000) per occurrence and at least one million dollars (\$1,000,000) aggregate in addition to workers compensation insurance).
- Floor Plan of the premises
- A signed passport-type of photograph taken within the preceding thirty (30) days
- A signed CORI/SORI acknowledgment form, authorizing the Town of Medway or a contracted third party to conduct a CORI/SORI inquiry and authorizing the report of these results to be reported to the Board.

- Name or names of individuals that are currently certified in basic cardiopulmonary resuscitation (CPR) and a copy of their valid certification. One individual trained in CPR must be on site at all times during operating hours.
- Copies of the Bodywork Therapist Permits for all therapists performing bodywork at the establishment. Must have at least one (1) duly permitted bodywork therapist employed at the establishment all times.
- Proof of a signed lease or other written authorization from the owner of the property where business is conducted
- Supporting documentation that every person with an ownership interest in the Establishment is twenty (21) years of age or older by presenting two forms of positive identification. One form must include a photograph, such as a valid state driver's license with photo, a state identification card with photo, and/or a valid passport. The second form of ID may be a certified long-form birth certificate or another government-issued photo ID.
- Name or names of individuals that are currently certified in basic cardiopulmonary resuscitation (CPR) and a copy of their valid certification. One individual trained in CPR must be on-site at all times during operating hours.



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.

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 #: _____

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-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services 200
Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



This form is not to be faxed. Please return form to organization.

**Criminal Offender Record Information (CORI)
Acknowledgement Form**

To be used by organizations using consumer reporting agencies to conduct CORI checks for employment, volunteer, subcontractor, licensing, and housing purposes.

_____ is registered under the
(Organization)
provisions of M.G.L. c.6, § 172 to receive CORI for the purpose of screening current and otherwise qualified prospective employees, subcontractors, volunteers, license applicants, current licensees, and applicants for the rental or lease of housing. _____ has authorized
(Organization)
_____ to submit CORI checks
(Consumer Reporting Agency)
to the Massachusetts Department of Criminal Justice Information Services (DCJIS) on its behalf.

As a prospective or current employee, subcontractor, volunteer, license applicant, current licensee, or applicant for the rental or lease of housing, I understand that a CORI check will be submitted for my personal information to the DCJIS. I hereby acknowledge and provide permission to _____

(Consumer Reporting Agency)
to submit a CORI check for my information to the DCJIS. This authorization is valid for one year from the date of my signature. I may withdraw this authorization at any time by providing _____

(Organization)
with written notice of my intent to withdraw consent to a CORI check. I also understand that this form is a CORI acknowledgement form and I am entitled to additional consumer reporting disclosure forms under the Fair Credit Reporting Act. If I have not received those disclosures, I should contact _____

(Organization)
to request this information.

FOR EMPLOYMENT, VOLUNTEER, AND LICENSING PURPOSES ONLY:

I also understand that the _____, on behalf of
(Consumer Reporting Agency)
_____ may conduct
(Organization)
subsequent CORI checks within one year of the date this Form was signed by me.

By signing below, I provide my consent to a CORI check and affirm that the information provided on Page 2 of this Acknowledgement Form is true and accurate.

Signature of CORI Subject

Date



THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF PUBLIC SAFETY AND SECURITY
Department of Criminal Justice Information Services
200 Arlington Street, Suite 2200, Chelsea, MA 02150
TEL: 617-660-4640 | TTY: 617-660-4606 | FAX: 617-660-5973
MASS.GOV/CJIS



SUBJECT INFORMATION

Please complete this section using the information of the person whose CORI you are requesting.
The fields marked with an asterisk (*) are required fields.

* First Name: _____ Middle Initial: _____

* Last Name: _____ Suffix (Jr., Sr., etc.): _____

Former Last Name 1: _____

Former Last Name 2: _____

Former Last Name 3: _____

Former Last Name 4: _____

* Date of Birth (MM/DD/YYYY): _____ Place of Birth: _____

* Last **SIX** digits of Social Security Number: ____ -- ____ ☐ No Social Security Number

Sex: _____ Height: ____ ft. ____ in. Eye Color: _____ Race: _____

Driver's License or ID Number: _____ State of Issue: _____

Father's Full Name: _____

Mother's Full Name: _____

Current Address

* Street Address: _____

Apt. # or Suite: _____ *City: _____ *State: _____ *Zip: _____

SUBJECT VERIFICATION

The above information was verified by reviewing the following form(s) of government-issued identification:

Verified by:

Print Name of Verifying Employee

Signature of Verifying Employee

Date

M.G.L. c. 6, § 178I REQUEST FOR SEX OFFENDER REGISTRY INFORMATION

SORB USE ONLY**SOR Form 4 (06/20)**