TOWN OF NORTHBRIDGE
OFFICE OF THE INSPECTOR OF BUILDINGS
14 Hill Street
Whitinsville, MA 01588
(508) 234-6577
Fax# (508) 234-0821

Commonwealth of Massachusetts

Sheet Metal Permit

Date : _____ Permit #_____

Estimated Job Cost: _____ Permit Fee: $_____

Plans Submitted: **YES** ____ **NO** ____ Plans Reviewed: **YES** ____ **NO** ____

Business License # _____ Applicant License # _____

Business Information: Property Owner / Job Location Information:

Name: _____ Name: _____

Street: _____ Street: _____

City/Town: _____ City/Town: _____

Telephone: _____ Telephone: _____

Photo I.D. required / Copy of Photo I.D. attached: **YES** ____ **NO** ____

Building Type:

Residential: 1-2 family ____ Multi-family ____ Condo / Townhouses ____

Commercial: Office ____ Retail ____ Industrial ____ Educational ____ Institutional ____

Building Cubic Footage: under 35,000 cu. ft. ____ over 35,000 cu. ft. ____

Sheet metal work to be completed: New Work: ____ Renovation: ____

HVAC ____ Metal Roofing ____ Kitchen Exhaust System ____ Chimney / Vents ____

Provide brief description of work to be done:

_____

_____

_____

_____

_____

INSURANCE COVERAGE:

I have a current liability insurance policy or its equivalent which meets the requirements of M.G.L. Ch. 112 Yes ☐ No ☐

If you have checked Yes, indicate the type of coverage by checking the appropriate box below:

A 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 112 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 Owner's Agent

By checking this box☐, 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 sheet metal work and installations performed under the permit issued for this application will be in compliance with all pertinent provision of the Massachusetts Building Code and Chapter 112 of the General Laws.

Progress Inspections

Date	Comments
_____	_____
_____	_____
_____	_____
_____	_____

Final Inspection

Date	Comments
_____	_____

By _____

Title _____

City/Town _____

Permit # _____

Fee $ _____

_____

Inspector Signature of Permit Approval

Type of License:

☐ Master

☐ Master-Restricted

☐ Journeyperson

☐ Journeyperson-Restricted

☐ _____

_____

Signature of Licensee

License Number: _____

Check at www.mass.gov/dpl

Effective 3-13-2013

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 #:** _____