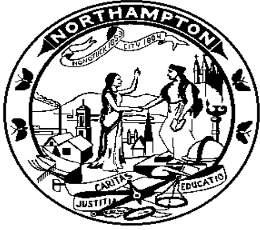

Department of Health & Human Services
Board of Health
212 Main Street
Northampton, MA 01060
Tel: (413) 587-1214
Commissioner: Merridith A. O'Leary, R.S.

FOR BOARD OF HEALTH USE ONLY
Date: ______________
Amt Received: ______________
Cash/Check No: ______________
Received by: ______________
Workers Comp Affidavit ☐
Collector's Approval ☐

2026 BATHING BEACH PERMIT APPLICATION

PERMIT FEE: $100.00 ALL FEES PAID ARE NON-REFUNDABLE

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

Beach Name: : ______________________________ Date of Application: ______________________
Beach Address: ____
Mailing Address: ____
Email Address: ____

Applicant/Operator Name and Title: ____
Applicant Address: ______________________________ Applicant Telephone #: ______________
Owner Name & Title (if different from applicant): _____________________________________
Owner Address: ____

Dates of Operation of Beach: From ______________________ to ______________________
Sampling Frequency (if not weekly, please explain): ______________________________________
____

Are Field Data Forms completed in full for each sampling event? ___________________________
Has Board of Health received timely notification of any exceedances/closures? _______________

For Board of Health Use Only

Does this beach meet the criteria set forth in 105 CMR 445.000? YES / NO (circle one)
APPROVED / DENIED (circle one) If Denied, Reason: ______________________________________
____

Board of Health Inspector: ____

Permit granted on ____________ and expires on ____________, pending submittal of a renewal application at least 30 days prior to expiration.

The Commonwealth of Massachusetts
Department of Industrial Accidents
Office of Investigations
1 Congress Street, Suite 100
Boston, MA 02114-2017
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 #:**______________________________