



**AVON BOARD OF HEALTH**  
 Buckley Center / 65 East Main St. / Avon, MA 02322  
 508-588-0414  
**www.avonmass.org**

**APPLICATION FOR  
 DISPOSAL WORKS INSTALLERS PERMIT**

Date: \_\_\_\_\_ Permit Number: \_\_\_\_\_ Annual Fee: \$150.00

**Application is hereby made to construct, alter, install or repair individual sewage disposal systems in the town of Avon, Massachusetts in conformity with Title 5 of the State Environmental Code, regulation 2.2**

Name of Applicant: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address:; \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

\_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Cellphone: Number: \_\_\_\_\_

\*\*Federal Identification Number or Social Security Number: \_\_\_\_\_

**Please complete the Authorization Form on the back of the Application.**

**I acknowledge that I am familiar with the local septic regulations and understand my responsibilities as outlined in these regulations. I understand that a minimum of twenty-four (24) hours notice must be given to the Board of Health office when requesting required inspections. I certify under the penalties of perjury that I, to the my best knowledge and belief, have filed all State tax returns and paid all State taxes required under the law.**

\_\_\_\_\_  
 \* Signature of Applicant/Officer

\_\_\_\_\_  
 Date

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

\*\* Your Social Security # will be furnished to the Massachusetts Department of Revenue to be determined 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 Laws, Chapter 62C, Section 49A.

***If you are applying for an installer's permit in Avon for the first time, you must provide copies of three recent installer's permits from other cities/town for references.***

All permits expire at the end of the calendar year.

Please return this application to the Board of Health along with the fee, Workmen's Compensation Affidavit and Certificate of Liability.

# AVON BOARD OF HEALTH 2009 AUTHORIZATION FORM

\_\_\_\_\_  
Company Name

\_\_\_\_\_  
Date

PLEASE LIST THOSE PERSON AUTHORIZED  
TO SIGN ON BEHALF OF YOUR COMPANY

Print Name

Signature

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Office Use Only
Fee: _____
W.C. Affid. _____
. Liability _____
ABOH Cust.#: _____