



CITY OF NEW BEDFORD HEALTH DEPARTMENT
1213 Purchase St. New Bedford, MA 02740
508-991-6199

SWIMMING, WADING AND SPECIAL PURPOSE POOL RENEWAL ADVISORY

Dear Permit Holder,

The Board of Health wishes to remind you that your Swimming, Wading or Special Purpose Pool Permit **will expire on December 31st.**

Please furnish all the requested information and return the completed application packet **by December 1st**. Any application received after December 1st will incur a late filing fee of 20% (\$50.00per pool/spa).

All applications must be filed at or mailed to:

City of New Bedford Health Department
1213 Purchase Street, New Bedford, MA 02740.

TO EXPEDITE THE PROCESSING OF YOUR PERMIT APPLICATION, PAYMENT MUST BE MADE IN THE FORM OF A CHECK, MONEY ORDER OR POSTAL NOTE PAYABLE TO THE CITY OF NEW BEDFORD IN THE AMOUNT OF **\$250.00 PER POOL/SPA.**

Important Reminders:

- Completed Swimming, Wading or Special Purpose Pool Permit Application is **due by December 1st** with the completed Worker's Compensation Insurance Affidavit .
- Each application must include:
 - ❖ **Copy of Pool Operator's Certificate**
 - ❖ **If applicable, copy of a Lifeguard Certificate, CPR Certificate, First Aid Certificate**
 - ❖ **Proof of required record keeping as cited by 105 CMR 435.21(5)**
(i.e., copy of a pool maintenance record sheet in use by your C.P.O.)

If you have any questions or require further assistance, please contact the New Bedford Health Department @ (508) 991-6199. This will be your only reminder.

Thank you for your cooperation.

New Bedford Board of Health

FOR BOARD OF HEALTH USE ONLY

DATE RECEIVED	DATE INSPECTED	APPROVED BY	PERMIT FEE: \$ _____	PERMIT ISSUED
_____	_____	_____	LATE FEE: \$ _____	DATE: _____
			TOTAL FEE = \$ _____	ID#: _____

CITY OF NEW BEDFORD HEALTH DEPARTMENT
1213 Purchase Street, New Bedford, MA 02740
TEL (508) 991-6199 • FAX 508-991-6292 • TTY/TTD (508) 979-1739

**ANNUAL APPLICATION FOR PERMIT TO OPERATE A
PUBLIC/SEMI-PUBLIC SWIMMING, WADING OR SPECIAL PURPOSE POOL**

Permit fee: \$ 250.00 per pool/spa

New business application must be submitted at least 30 days prior to proposed opening date.

Renewal applications received after December 1st, will be charged a 20% late filing fee.

PLEASE PRINT CLEARLY

Payment is due with application

Check type of application: ☐ **New (Initial)** ☐ **Renewal** ☐ **Amended**

TYPE(S) OF POOL: (Check all that apply)

DATE: _____

<input type="checkbox"/> Public /* Style:	<input type="checkbox"/> Semi- Public /*Style:	<input type="checkbox"/> Wading /*Style:	<input type="checkbox"/> Special Purpose /*Style:
<input type="checkbox"/> Indoor	<input type="checkbox"/> Indoor	<input type="checkbox"/> Indoor	<input type="checkbox"/> Indoor
<input type="checkbox"/> Outdoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Outdoor

***OPERATOR/APPLICANT NAME:**

LOCATION/ADDRESS OF POOL OPERATION:

MAIL ADDRESS(IF DIIFERENT): _____

***105 CMR 435.01 –**

Operator is defined as:

- a) Alone or jointly or severally with others that owns a public/semi-public swimming, wading or special purpose pool;
b) Has care, charge or control of such pool as an agent or lessee of the owner as an independent contractor.

OPERATOR'S TELEPHONE / EMAIL ADDRESS: () / _____

POOL SUPERVISOR NAME: _____

CERTIFIED POOL OPERATOR: ☐ **YES (ATTACH VERIFICATION)** ☐ **NO**

PERSON IN CHARGE OF MAINTENANCE: _____ **Contact #:** _____

NUMBER OF LIFEGUARDS REQUIRED: _____

LIFEGUARD WAIVER FROM B.O.H.: ☐ **YES** ☐ **N/A**

NAME OF CERTIFIED LIFEGUARD: _____ **(Attach Verification)**

*****POOL INFORMATION*****

CONSTRUCTION MATERIAL: ☐ **Public** ☐ **Semi- Public**

YEAR BUILT: _____ **LENGTH:** _____ **WIDTH:** _____ **VOLUME:** _____

TOTAL SQUARE FOOTAGE OF:

SWIMMING AREA

NON-SWIMMING AREA

DIVING AREA

WADING POOL CONSTRUCTION MATERIAL:

YEAR BUILT: _____ LENGTH: _____ WIDTH: _____ VOLUME: _____

TOTAL SQUARE FOOTAGE: _____

SPECIAL PURPOSE POOL CONSTRUCTION MATERIAL:

YEAR BUILT: _____ LENGTH: _____ WIDTH: _____ VOLUME: _____

TOTAL SQUARE FOOTAGE: _____

METHOD OF WATER TREATMENT:

MAXIMUM CAPACITY OF PUBLIC / SEMI PUBLIC POOL(S):

A) SWIMMERS : _____

B) NON-SWIMMERS: _____

POOL OPERATION DATES: _____

POOL HOURS: _____

Establishment Owner's Tax Identification Number as reported to Massachusetts Department of Revenue:

✓ *If owned by an individual:*

☐ Date of Birth (D.O.B.) _____ ☐ Social Security Number: _____

✓ *If owned by an association, corporation, partnership, or other legal entity:*

☐ Federal Employer Identification Number: _____

Pursuant to MGL c. 62C, sec. 49A, I certify under the penalties of perjury that the owner (s) of this establishment, to the best of my knowledge and belief, have filed all applicable tax returns and paid all taxes required under law. I, the undersigned, attest to the accuracy of the information provided in this application, and affirm that this swim, wading or special purpose pool facility will comply with 105 CMR 435.000 and all other applicable law. Upon request, I will be instructed by the Department of Health on how to obtain copies of MGL c. 111, sec. 127A and CMR 435.000.

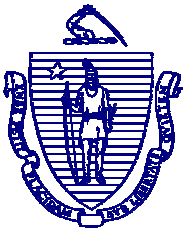
I authorize the city, its agents and employees to seek information and conduct an investigation into the truth of the statements set forth in this application.

Owner's / Authorized Officer's Signature – *Print* name, title, *sign* and date below:

Print Name: _____ **Title:** _____

Signature: _____ **Date:** _____

Reminder: Consistent with M.G.L. Ch.270, Section 22 and per order of the New Bedford Board of Health, Pool/Spa operations must prohibit smoking on the premises in all common areas at all times and post smoke-free notices in a clear and conspicuous manner at each entrance, restrooms, and common areas upon the premises. Signage is available at the New Bedford Health Department or online at www.makesmokinghistory.com/secondhand-smoke



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 #: _____

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 Office of Investigations would like to thank you in advance for your cooperation and should you have any questions, please do not hesitate to give us a call.

The Department's address, telephone and fax number:

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

Tel. # 617-727-4900 ext 406 or 1-877-MASSAFE

Fax # 617-727-7749

www.mass.gov/dia