Application #

Town of Stoughton

BOARD OF HEALTH

Recreational Camp for Children
Application

Date: _____

( ) New: $300.00

( ) Renewal: $200.00

Owner Information: *(Home and Personal Information)*

Name of Camp Owner: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Operator Information *(if different from the Owner)*

Name of Camp Operator: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Title: _____

Camp Information

Name of Camp: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Camp Type:
( ) Day ( ) Residential ( ) Overnight

Days and Hours of Operation:
( ) Consistent days and hours _____ –_____, *(__:__ - __ :__)*
Day *Day* *Open & close time*

( ) Variable days and hours
Sun (__:__ - __ :__) Mon (__:__ - __:__) Tue (__:__ - __:__) Wed (__:__ - __:__)

T*hu (__:__ - __:__) Fri (__:__ - __:__) Sat (__:__ - __:__)*

Swimming Pool:
Swimming Pool available: ( ) Yes ( ) No

If Yes *(Swimming Pool is available)*; Please choose one of the following:

( ) Yes Permit obtained, Permit #: _____
( ) Application submitted, Application #: _____
( ) Application needs to be completed

Meals:

Meals Provided: ( ) Yes ( ) No

If Yes *(Meals provided)*; Please choose one of the following:

( ) Yes Permit obtained, Permit #: _____
( ) Application submitted, Application #: _____
( ) Application needs to be completed

Water, Sewer and Trash Information:
Water Supply: ( ) Public ( ) On-site

Sewage Disposal: ( ) Public ( ) On-site Septic

Grease Hauler Company Name: _____ (**N/A** *indicate if not applicable*)

Septic Hauler Company Name: _____ ((**N/A** *indicate if not applicable*)

Trash Hauler Company Name: _____

Staff Information

Camp Director
Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

☐ Attach Resume *(Please make sure to spell out all Coursework in camping administration previous camp administration experience)*

Health Care Consultant

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Type of Medical License: ( ) Physician ( ) Nurse Practitioner

( ) Physician Assistant with Pediatric Training

MA License Number: _____

Health Supervisor

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Type of Medical License, Registration or Training (See 105 CMR 430.159(C):

Aquatics Director

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

Lifeguard Certificate issued by: _____

Attach copy of certificate(s):

- ☐ American Red Cross CPR Certificate
- ☐ American First Aid Certificate

☐ Attach Resume *(Please make sure to spell out all previous aquatics supervisory experience)*

Firearms Instructor

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Initial:_____

Tel #: _____

Email: _____

☐ Attach copy of National Rifle Association Instructor's card (or equivalent)

Horseback Riding Instructor

Name: _____

Address: _____

City _____ State: _____ Zip: _____

Tel #: _____

Email: _____

License Number: _____ Expiration date:_____

☐ Attach copy of the License

Stable Information

Address: _____

Licensed in accordance with MGL Ch.111 § 155, 158: ( ) Yes ( ) No

---

☐ **Attach** the name, age, applicable current certifications (if any), such as First Aid, and the anticipated role at the camp of all supervisory staff① (see below). Use as many pages as necessary to complete this.

 # Staff per season: _____

 # Volunteers per season: _____

 # Campers per season: _____

①Supervisory staff: Persons with the responsibility, authority and training to provide direct supervision to camper groups. This may include counselors, junior counselors, general activity leaders or other staff who provide supervision to campers without assistance.

==========

I declare under penalty or perjury all the following: 1) The statements made on the application are true and correct; 2) I have knowingly and willfully made truthful statements and included factual documents in support of this application; 3) I have filed all state tax returns and paid all taxes required under law; 4) I cannot conduct business until the Board of Health Permit is obtained.

Date _____
Print Name _____
Signature _____

========== For New Application Only ==========

Required Documents
See the MA Regulations for Minimum Standards for Recreational Camps for Children, State Sanitary Code, Chapter IV - 105 CMR 430.000 and the guidance documents issued by the Department of Public Health, Division of Community Sanitation for additional assistance with developing the following documents.

- ☐ Procedures for the background review of staff (105 CMR 430.090)
- ☐ Copy of promotional literature (105 CMR 430.190(C))
- ☐ Procedures for reporting suspected child abuse or neglect (105 CMR 430.093)
- ☐ Health care policy (105 CMR 430.159(B))
- ☐ Discipline policy (105 CMR 430.191)
- ☐ Fire evacuation plan – approved by local fire department (105 CMR 430.210(A))
- ☐ Disaster plan (105 CMR 430.210(B))
- ☐ Lost camper plan (105 CMR 430.210(C))
- ☐ Lost swimmer plan (105 CMR 430.210(C))
- ☐ Traffic control plan (105 CMR 430.210(D))
- ☐ Day Camps – contingency plan (105 CMR 430.211)
- ☐ Primitive, Trip or Travel Camps – Written itinerary, including sources of emergency care, and contingency plans (105 CMR 430.212)
- ☐ Current certificate of occupancy from local building inspector (105 CMR 430.451)
- ☐ Written statement of compliance from the local fire department (105 CMR 430.215)
- ☐ Lab analysis of private water supply (well) is required (105 CMR 430.300, .303)

Please note: If applying for an initial camp license, the initial camp application must be received within 90 days before the planned opening date. The plan shall include the following
(See MGL Ch. 140 s. 32A):

- ☐ Building(s)
- ☐ Structure(s) (i.e. playgrounds, Pools)

FOR OFFICE USE ONLY

Payment Type:
( ) Cash ( ) Check # _____ ( ) Money Order # _____

Date Payment Received: _____

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

Form Revised 5-26-05