



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	<input type="checkbox"/>
CPO Certification	<input type="checkbox"/>
Bather Load #	<input type="checkbox"/>
VGB Documentation	<input type="checkbox"/>
Collector's Approval	<input type="checkbox"/>

## 2026 POOL/HOT TUB/WATER SLIDE PERMIT APPLICATION

**ALL FEES PAID ARE NON-REFUNDABLE**

**NO PERMITS WILL BE ISSUED IF TAXES ARE OWED**

*Application is hereby made for a permit to operate a public, semi-public, swimming, wading, specialty pool, hot tub, or water slide. This pool, tub or slide is to be operated according to the minimum standards for swimming pools set forth in 105 CMR 435.000 chapter V: Minimum Standards for Swimming Pools.*

Establishment Name: (dba): \_\_\_\_\_ Establishment Tel.#: \_\_\_\_\_

Establishment Address: \_\_\_\_\_

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

Email Address: \_\_\_\_\_

Applicant Name and Title: \_\_\_\_\_

Applicant Address: \_\_\_\_\_ Applicant Telephone #: \_\_\_\_\_

Owner Name & Title (if different from applicant): \_\_\_\_\_

Owner Address: \_\_\_\_\_

Establishment Owned by (Check one Box)      Please attach List of Corporate and Partnership Officers

An Association     
  A Corporation     
  An Individual     
  A Partnership     
  Other Legal Entity

If a Corporation or Partnership, give Name, Title, and Home Address of Officers or Partners

Name	Title	Home Address
_____	_____	_____

**PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON**

Name of Person in Charge: \_\_\_\_\_

Signature of Applicant or Corporate Signature: \_\_\_\_\_

**POOL, TUB, OR SLIDE ESTABLISHMENT INFORMATION**

Days, and Hours of Operation: \_\_\_\_\_

**PLEASE ATTACH COPIES OF CERTIFIED POOL OPERATOR**

Name of CERTIFIED POOL OPERATOR: \_\_\_\_\_

**PLEASE ATTACH COPIES OF ALL LIFE GUARDS**

Please attach copies of manufacturer's documentation for pool drain/grate covers conform to the American National Standard ASME A112.19.8 – 2007, Federal Pool and Spa Safety Act and 105 CMR 435.00: Department of Public Health.  
[pool-federal-requirements.rtf - Google Docs](#)

Date of Opening: \_\_\_\_\_ Date of Closing: \_\_\_\_\_

Name of LIFE GUARDS: \_\_\_\_\_

Check all that apply and complete the following

√	Pool, Tub, Slide Type	License Fees	Pool Type	Length	Width	Volume	Maximum Bather Load
	Annual Pool	\$250.00 per pool					
	Seasonal Pool	\$150.00 per pool					
	Hot Tub	\$37.50 per tub					
	TOTAL		<b>PLEASE MAKE CHECKS PAYABLE TO THE CITY OF NORTHAMPTON</b>				

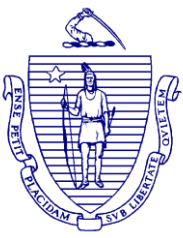
Water Source:     Public     Well                      Sewage Disposal:     Public     Well

Treatment System (Kinds of Filters, etc.)	
Disinfection Method (Type, capacity, etc.)	
Chemical Treatment (Feeders, capacity, quantity)	
Turn Over Rate	

I, the undersigned, attest to the accuracy of the information provided in this application and I affirm that this application to operate a pool, tub, or slide will comply with 105 CMR 435.000 Chapter V: Minimum standards for swimming pools and all other applicable law.

Signature of Applicant: \_\_\_\_\_

*Pursuant to MGL Chapter 62C, section 49A, I certify under the penalties of perjury that, to my best knowledge and belief, complied with the law of the Commonwealth relating to taxes, reporting of employees and contractors, and withholding and remitting child support.*



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 #: \_\_\_\_\_