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
Amt Received: _____
Cash/Check No: _____
Received by: _____
Workers Comp Affidavit ☐

2024 RECREATIONAL CAMP PERMIT APPLICATION

PERMIT FEE: $200.00: ALL FEES PAID ARE NON-REFUNDABLE

NO PERMITS WILL BE ISSUED IF TAXES ARE OWED

In accordance with the provisions of 105 CMR 430.000, chapter IV of the State Sanitary code, application is hereby made for a Permit to operate a Recreational Camp for Children in Northampton, Massachusetts

Date: _____

Name of Camp: _____

Site Address: _____

Site Telephone: _____

Name of Camp Owner: _____

Office Address: _____ Owner/Office Telephone #: _____

Email Address: _____

Name of Camp Operator (if different): _____

Address: _____ Camp Operator Telephone #: _____

Name of Health Care Consultant: _____

Address: _____ Consultant Telephone #: _____

Type of Medical License (must be a physician, nurse practitioner, or physician assistant with pediatric training: _____

Massachusetts License Number: _____

Health Supervisor Name: _____Age: _____

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

_____

Name of Camp Director: _____Age: _____

Course Work in Camping Administration: _____

Previous Camp Administration Experience: _____

2022 RECREATIONAL CAMP APPLICATION FOR PERMIT

TYPE OF CAMP (CHECK WHICH TYPE APPLIES)

DAY		RESIDENTIAL		PRIMITIVE, TRAVEL, TRIP		SPORT	

Maximum Number of Campers Allowed Per Session: _____

Operating Days Per Year: _____

Age Range of Campers: _____

Average Number of Supervisory Camp Counselors: _____ Per Session: _____

Average Number of Junior Counselors: _____ Per Session: _____

Hours of Operation	Camp begins:_____						
	SESSION 1	OPENING:		CLOSING:		Location:	
	SESSION 2	OPENING:		CLOSING:		Location:	
	SESSION 3	OPENING:		CLOSING:		Location:	
	SESSION 4	OPENING:		CLOSING:		Location:	
	SESSION 5	OPENING:		CLOSING:		Location:	
	SESSION 6	OPENING:		CLOSING:		Location:	
	SESSION 7	OPENING:		CLOSING:		Location:	
	SESSION 8	OPENING:		CLOSING:		Location:	
	SESSION 9	OPENING:		CLOSING:		Location:	
	SESSION 10	OPENING:		CLOSING:		Location:	
List Dates of Operation, Opening, Closing and Location for all Sessions							
TOTAL # OF DAYS IN OPERATION PER YEAR:		TOTAL:					

Signature of Camp Official & Title: _____

Social Security or Federal ID Number: _____

PLEASE MAKE ALL CHECKS PAYABLE TO THE CITY OF NORTHAMPTON

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 #:_____