

FEE: \$300  
Non-refundable application fee

OFFICE OF THE  
**BOARD OF HEALTH**  
13 East Central St., Natick MA 01760

Telephone 508-647-6460  
Fax- 508-647-6466  
health@natickma.org  
<https://www.natickma.gov/>

**APPLICATION TO OPERATE A TANNING FACILITY**

Date: \_\_\_\_\_

**1. Type of Application**

New-Complete all sections     Renewal-Complete sections 1-6, & 8

*A Late Fee of 25% will be due after July 1<sup>st</sup> of each year.*

Name of Establishment: \_\_\_\_\_

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

Mailing Address (if different than above): \_\_\_\_\_

Phone Number on site: \_\_\_\_\_

**2. Hours of Operation**

Sun: \_\_\_\_\_ Mon: \_\_\_\_\_ Tue: \_\_\_\_\_ Wed: \_\_\_\_\_ Thurs: \_\_\_\_\_ Fri: \_\_\_\_\_ Sat: \_\_\_\_\_

**3. Applicant Information**

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

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Title: \_\_\_\_\_

**4. Owner Information**

Name of Owner: \_\_\_\_\_

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

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

- If ownership is a partnership or corporation, attach a list of officer names, address and phone numbers

**5. Manager/Person-In-Charge/Operator Information**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

**6. 24-Hour Contact Information**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**7. Operation of Tanning Facility Information**

Will all operators be above 18 years old?  Yes  No

Will a trained operator be present at the tanning facility at all times during operation hours?  Yes  No

Will each operator be trained and sufficiently knowledgeable in the correct operation of tanning devices used at a facility (in accordance with 105 CMR 123.003(4, 6, 7, 8))?  Yes  No

Will the Physical Plant be in compliance with all the provisions of 105 CMR 123.003 (B)?  Yes  No

Type of Eyewear:  Disposable  Other (please specify): \_\_\_\_\_

If eyewear is not disposable, name of chemical used to sanitize the eyewear: \_\_\_\_\_

**8. List of Operators**

Use a separate sheet if necessary

Name	Date of Birth

**9. Sanitation**

Name of Disinfect Cleaner(s) for the tanning device(s): \_\_\_\_\_

Contact Time for Disinfection (according to the manufacturer label): \_\_\_\_\_

Will a shower(s) be provided?      Yes      No

Will each customer have access at all times to potable drinking water?      Yes              No

Describe your cleaning and disinfecting procedures for both the facility and the tanning devices:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of tanning device supplier: \_\_\_\_\_

Address of the tanning device supplier: \_\_\_\_\_

Name of Installer: \_\_\_\_\_

Name of Service Agent: \_\_\_\_\_

**For New Applicants: Submit a sketch of the Tanning Facility and identify areas including restrooms**

**10. Tanning Device Information**

TYPE OF DEVICE		MODEL #	MANUFACTURER	MODEL #	MODEL YEAR	SERIAL #	LAMP TYPE
Bed	Booth						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						
<input type="checkbox"/>	<input type="checkbox"/>						

Statement: I, \_\_\_\_\_ have read and understand of 105 CMR 123.000 "Department of Public Health Tanning Facilities Rules and Regulations." I understand that I shall notify the Natick Board of Health in writing before making any change which would render the information reported pursuant to 105 CMR 123.005 and contained in the application for license no longer accurate (this does not include lamp replacement). Pursuit to MGL Chapter 62C, Section 49A, I certify under the penalties of perjury that I, to my best knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

Signature: \_\_\_\_\_ Print: \_\_\_\_\_

Title: \_\_\_\_\_

**To obtain a License to Operate a Tanning Facility please submit the following:**

- Completed "Application for Permit to Operate a Tanning Facility". Incomplete applications and missing documents may cause a delay in the permit process. Do not leave any blank spaces.
- Fee \$300 made payable to the "Town of Natick". Credit cards are not accepted at this time. **All fees are non-refundable.** Check, complete application and required documents can be mailed together to: The Board of Health, 13 East Central St., Natick MA 01760
- Completed "Workers' Compensation Insurance Affidavit" form including the first page of the policy. See page 4.
- A copy of the forms customers will complete and sign.
- A copy of the injury report.
- Sketch of Tanning Facility and identify areas including restrooms – **For New Applicants/ Owners/ Renovations of an existing facility.**
- A copy of the operating and safety procedures to be followed in the operation of the facility and the tanning device – **For New Applicants/Owners**

**For Official Use Only**

- Approved as submitted
- Approved as submitted with the following conditions: \_\_\_\_\_  
\_\_\_\_\_
- Disapproved as submitted - Reason(s): \_\_\_\_\_  
\_\_\_\_\_

Reviewed By: \_\_\_\_\_ Title: \_\_\_\_\_

Date Reviewed: \_\_\_\_\_ Date Permit was Issued: \_\_\_\_\_



The Commonwealth of Massachusetts  
 Department of Industrial Accidents  
 Office of Investigations  
 Lafayette City Center  
 2 Avenue de Lafayette, Boston, MA 02111-1750  
 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 § 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 (check 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."

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## 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.

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## 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.

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The Department's address, telephone and fax number:

The Commonwealth of Massachusetts  
Department of Industrial Accidents  
**Office of Investigations**  
Lafayette City Center  
2 Avenue de Lafayette,  
Boston, MA 02111-1750  
Tel. (857) 321-7406 or 1-877-MASSAFE  
Fax (617) 727-7749  
[www.mass.gov/dia](http://www.mass.gov/dia)