



# Town of Mansfield

## Inspections Department

6 Park Row

Mansfield, Massachusetts 02048

Tel: 508-261-7360 Fax: 508-261-7343

### APPLICATION TO CONSTRUCT, REPAIR, RENOVATE OR DEMOLISH A ONE OR TWO FAMILY DWELLING

#### This Section For Official Use Only

Building Permit Number:

Date Issued:

Signature:

\_\_\_\_\_  
Building Commissioner/Zoning Enforcement Officer

\_\_\_\_\_  
Date

#### SECTION 1-SITE INFORMATION

1.1 Property Address:

1.2 Assessors Map, Block, Parcel & Value:

Map:      Block:      Parcel:      Structure Value:

1.3 Zoning Information:

1.4 Property Dimensions:

Zoning District:      Proposed Use:

Lot Area (sf):      Lot Frontage:  
Upland Area:      Width at House:

1.5 Building Setbacks:      R1 - 25' sides, 40' front & rear; R2,R3 & RD - 15' sides, 30' front and rear

Front Yard

Side Yards

Rear Yard

Required

Provided

Required

Provided

Required

Provided

1.6 Water Supply (M.G.L. c. 40, §54)

Public:      Private:

1.7 Flood Plain Information

FIRM Zone:      Town (y/n):

1.8 Sewage Disposal System

Municipal:      Private:

#### SECTION 2- PROPERTY OWNERSHIP & AUTHORIZED CONTRACTOR

2.1 Owner of Record:

Name (Print)

Address for Service:

Telephone:

2.2 Authorized Contractor

Name (Print)

Address for Service:

Telephone:

#### SECTION 3- CONSTRUCTION SERVICES

3.1 Licensed Construction Supervisor:

Name (Print)

Phone:

Address for Service:

License & Exp:

3.2 Registered Home Improve Contractor

Company Name (Print)

Phone:

Address for Service:

Registration & Exp:

#### SECTION 4- WORKERS COMPENSATION INSURANCE AFFIDAVIT (M.G.L. c.152, §25C (6))

Workers Compensation Insurance Affidavit must be completed and submitted with this application. Failure to provide this affidavit will result in the denial of the building permit.

Signed Affidavit Attached:      Yes:      No:





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: Builders/Contractors/Electricians/Plumbers**  
**Applicant Information** **Please Print Legibly**

Name (Business/Organization/Individual): \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ Phone #: \_\_\_\_\_

**Are you an employer? Check the appropriate box:**

- |  |  |
|--|--|
| <p>1. <input type="checkbox"/> I am an employer with _____ employees (full and/or part-time).*</p> <p>2. <input type="checkbox"/> I am a sole proprietor or partnership and have no employees working for me in any capacity. [No workers' comp. insurance required.]</p> <p>3. <input type="checkbox"/> I am a homeowner doing all work myself. [No workers' comp. insurance required.] †</p> | <p>4. <input type="checkbox"/> I am a general contractor and I have hired the sub-contractors listed on the attached sheet. These sub-contractors have employees and have workers' comp. insurance.‡</p> <p>5. <input type="checkbox"/> We are a corporation and its officers have exercised their right of exemption per MGL c. 152, §1(4), and we have no employees. [No workers' comp. insurance required.]</p> |
|--|--|

**Type of project (required):**

6.  New construction
7.  Remodeling
8.  Demolition
9.  Building addition
10.  Electrical repairs or additions
11.  Plumbing repairs or additions
12.  Roof repairs
13.  Other \_\_\_\_\_

\*Any applicant that checks box #1 must also fill out the section below showing their workers' compensation policy information.  
 † Homeowners who submit this affidavit indicating they are doing all work and then hire outside contractors must submit a new affidavit indicating such.  
 ‡ Contractors that check this box must attached an additional sheet showing the name of the sub-contractors and state whether or not those entities have employees. If the sub-contractors have employees, they must provide their workers' comp. policy number.

**I am an employer that is providing workers' compensation insurance for my employees. Below is the policy and job site information.**

Insurance Company Name: \_\_\_\_\_

Policy # or Self-ins. Lic. #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Job Site Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

**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. Electrical Inspector 5. Plumbing Inspector  
 6. Other \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_