



THE COMMONWEALTH OF MASSACHUSETTS

Town of Hanover

550 Hanover Street – Suite 17, Hanover, MA 02339

Tel: (781) 826-4611 Fax: (781) 826-5289

**APPLICATION FOR A 2017 PERMIT FOR REMOVAL
OR TRANSPORT OF GARBAGE, OFAL OR OTHER
OFFENSIVE SUBSTANCES IN THE TOWN OF HANOVER**

Date: _____, ____

Permit # _____

Fee: \$100.00

Upon Review of the application and receipt of the permit fee, a numbered permit, valid for a calendar year, will be issued by the Board of Health. Annual renewal of the permit must be accompanied by a completed application. Failure to renew your permit by December 31st each year will result in a fine.

Type(s) of waste product(s) for which a permit is sought (check as many as apply):

_____ Garbage (food waste)

_____ Rubbish/Refuse

_____ Infectious Waste

_____ Cesspool/Septic tank content/portable toilets

Name of Company: _____ # of Trucks _____

Address: _____

Owner: _____ Manager: _____

Tel # _____ Fax # _____ **E-mail:** _____

Provide the following information for each company, industry, municipality, hospital, agency, etc., for which you provide services in the Town of Hanover. (Attach an additional sheet if necessary to list all companies serviced.)

- A.
1. Name and address of company: _____

 2. Company contact person (Name, title, phone): _____

 3. Number of visits for removal per month: _____

 4. Type of product removed and/or transported: _____

 5. Facility where product is disposed: Type: (Circle one)
Landfill Incinerator Transfer Station Other _____ (Specify)

Facility Name: _____
Address: _____

- B
1. Name and address of company: _____

 2. Company contact person (Name, title, phone): _____

 3. Number of visits for removal per month: _____

 4. Type of product removed and/or transported: _____

 5. Facility where product is disposed: Type: (Circle one)
Landfill Incinerator Transfer Station Other _____(Specify)

Facility Name: _____
Address: _____
- C.
1. Name and address of company: _____

 2. Company contact person (Name, title, phone): _____

 3. Number of visits for removal per month: _____

 4. Type of product removed and/or transported: _____

 5. Facility where product is disposed: Type: (Circle one)
Landfill Incinerator Transfer Station Other _____(Specify)

Facility Name: _____
Address: _____

I hereby certify that under the pains and penalties of perjury, that to the best of my knowledge, the information provided on this application is complete and accurate and not misrepresented in any way. The undersigned agrees to comply with all the Federal, State and Local Regulations.

Date: _____ Name: (print) _____

Signature: _____

Title: _____

If any information provide on this application changes, or new companies are added, notification of such changes must be made to the Board of Health within 30 days of said changes or additions.