TYNGSBOROUGH BOARD OF HEALTH
25 BRYANT LANE
TYNGSBOROUGH, MA. 01879
978-649-2300 X 118
Boardofhealth@tyngsboroughma.gov

Well Construction Permit ($50)

WELL LOCATION **PERMIT #_____**

Property Address_____ Assessors Parcel ID:___ _____ _____

DRILLER'S INFORMATION

Company Name _____

Company Address_____

Phone #_____ Email_____

Driller's Name _____ Mass State License # _____

OWNER'S INFORMATION

Owner _____ Mailing Addresss_____

Phone_____ Email_____

Owner's Signature_____ Date:_____

WELL CONSTRUCTION

Type of Construction: ☐ New ☐ Deepen existing well ☐ Repair ☐ Decommission

Well use (check all that apply): ☐ Potable ☐ Irrigation ☐ Geothermal (provide MassDEP UIC Reg#) _____

☐ Other: Please describe_____

SETBACK DISTANCES

Enter the shortest distance between proposed well location and the features describe below. Enter "NA" if distance is greater than 200 feet.

Existing and proposed building structures: _____ feet

Utility right-of-way: _____ feet

Subsurface soil absorption system (Title 5 sanitary wastewater leaching field): [Note that Title 5 regulations require a minimum setback of 100 feet] _____ feet

Title 5 septic tank, holding tank, pump chamber, treatment unit, or grease trap: [Note that Title 5 regulations require a minimum setback of 50 feet] _____ feet

Sanitary wastewater pipeline: _____ feet

Subsurface fuel storage tank: _____ feet

Public and private roads: _____ feet

Property line: _____ feet

List other potential source of pollution, if applicable: _____

WELL LOCATION **PERMIT #_____**

Property Address_____ Assessors Parcel ID:___ _____ _____

Document and Certifications

Attach the following:

1. Site plan with a specified scale, signed by a registered surveyor or engineer, showing the location of the proposed well in relation to existing or proposed above or below ground structures. Plan showing the location of the existing and/or proposed well and septic systems **within 150 feet** of the proposed well shall be noted. (new construction only)

2. Copy of well driller's MassDEP Certification

After the installation, please submit the following:

- WATER TESTS REPORT must be submitted to the BOARD OF HEALTH OFFICE within 30 DAYS of drilling the well. For irrigation wells, E. coli bacteria and Nitrate/Nitrite
    - All samples for regulatory purposes shall be drawn by personnel from a **MA certified laboratory, MA certified well driller, MA licensed Title 5 inspector (for Title 5 inspection only) or Board of Health Agent**
- A WELL COMPLETION REPORT
- Decommissioned Well Report (If applicable)
- Irrigation Well Affidavit (if will be used for irrigation only)
- Pump Test Report

I hereby certify that I have read and fully understand the Tyngsborough Board of Health Well Regulation and that I agree to fully comply with said regulations and above items numbered 1-6. I further certify that the information provided on this application is complete and true.
Pursuant to Massachusetts General Laws Chapter 62C, section 49A, I certify under the pains and penalties of perjury that I, to the best of my knowledge and belief, have filed all state tax returns and paid all state taxes required under law.

_____ _____ _

Driller's Signature Date

WELL COMPLETION CHECKLIST

Well Completion Report	**Date:**_____	**By:**_____
Water Test Report (with Chain of Custody)	**Date:**_____	**By:**_____
Laboratory Name _____		Phone #_____
Pump Test Well Report	**Date:**_____	**By:**_____
Irrigation Well Affidavit	**Date:**_____	**By:**_____
Decommissioned Well Report	**Date:**_____	**By:**_____

BOARD OF HEALTH:_____ **DATE:**_____

Water Testing Required for New Private Wells

PARAMETER	LIMIT
Arsenic	.010 mg/L
Barium	1.0 mg/1
Cadium	0.01 mg/1
Chloride	250 mg/1
Chlorine	N.D.
Chromium	0.05 mg/1
Coliform	0/Plate Allowed
Color	15 Units
Copper	1.3 mg/L
Detergent	_____
Fluoride	3.0 mg/1
Iron	.3 mg/1
Lead	0.015 mg/L
Manganese	.050 mg/L
Mercury	0.002 mg/1
Nitrate/ Nitrate	10 mg/1
pH	6.5-8.5 Units
Selenium	0.01 mg/1
Silver	0.05 mg/1
Sodium	20 mg/1
Odor	3 TON (Threshold Odor Number)
Total Hardness	250 mg/1
Total Coliform Bacteria	*Absent*
Turbidity	1.0 Units
Volatile Organic Compounds	
Gross Alpha Particles	*15 pCi/L
*If the gross alpha result is greater than 15 pCi/l then uranium testing should be performed. If the gross alpha result is greater than 5 pCi/l then Radium-226 and Radium-228 testing should be performed.	
Radium (226+228)	5pCi/L
Uranium	0.030
Radon-222	10,000 pCi/L

Tyngsborough Board of Health

25 Bryants Lane, Tyngsborough, MA 01879
Office: 978-649-2300 x 118
Fax: 978-649-2326
BoardofHealth@tyngsboroughma.gov

Date

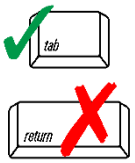
Previously issued well construction permit #

Pumping Test Report

Private Wells

A. General Information

Please Print
Important: When filling out forms on the computer, use only the tab key to move your cursor - do not use the return key.



Address of property

Assessor's map

Parcel

Property owner

B. Certification

Name of well drilling company

Well driller certification number

Name of well driller

Phone

Signature of well driller

Date signed

I certify under penalty of law that I am the person authorized to fill out this form and the information contained herein is true, accurate, and complete to the best of my knowledge and belief.

C. Well Construction Details

All depth measurements should be accurate to hundredths of a foot.

Type of well

Use

Diameter of open borehole or well screen (in inches)

Diameter of well casing (in inches)

Depth to bedrock (feet below ground surface)

Depth of well casing (feet below ground surface)

Seal has been tested Yes ☐ No ☐

Date of test

Depth of well

Depth to static water level (feet below ground surface)

Date of well completion

D. Pumping Test Results

All depth measurements should be accurate to hundredths of a foot.

Date pumping test performed: _____

Well casing stickup at time of pumping test (feet above grade): _____

Static water level immediately prior to start of pumping test (feet below top of well casing): _____

Depth of pump setting during pumping test (feet below top of well casing): _____

Distance between well and point of discharge (in feet): _____

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Private Wells

D. Pumping Test Results (continued)

Duration of pumping portion of test: _____

Duration of recovery portion of test (not to exceed 24 hours): _____ hours and _____ minutes.

Maximum drawdown (feet below top of well casing): _____

Final recovery water level measurement (taken at the end of the recovery portion of test at the time listed above in feet below top of well casing): _____

Enter the result from the following calculation using the information that you entered above: [final depth to recovery water level minus (–) depth to static water level] divided by [depth to maximum drawdown minus (–) depth to static water level] = _____ (rounded to the nearest hundredths).

If the result from the above calculation is 0.15 or less, the well meets the recovery requirements.

Well yield (in gallons per minute): _____

E. Table

Attach to this application form, a table showing the following information regarding the pumping test:

Time (HH:MM)	Measured water level (depth in feet below top of well casing)	Pumping rate (in gallons per minute)	Comments
_____	_____	_____	_____

Use the comments field in combination with time entries to note the following:

- start of pumping test
- time of any temporary pump shutdowns during test
- time of any restarts at end of temporary shut down
- time of final pump shut down

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street, Suite 100
Boston, MA 02114-2017
www.mass.gov/dia

Workers' Compensation Insurance Affidavit: General Businesses.
TO BE FILED WITH THE PERMITTING AUTHORITY.

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 #:_____

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."

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.

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 Department's address, telephone and fax number:

The Commonwealth of Massachusetts
Department of Industrial Accidents
1 Congress Street
Boston, MA 02114-2017

Tel. # 617-727-4900 ext. 7406 or 1-877-MASSAFE
Fax # 617-727-7749
www.mass.gov/dia

Form Revised 02-23-15