PERMIT # _____ FEE $100.00 RECEIVED DATE _____ CHECK # _____

Town of Granby
Board of Health
215B West State Street
Granby, MA 01033
413-467-7174 413-467-3101 Fax
boh@granby-ma.gov

Dear Licensee:

Please complete, sign and present or mail this application with permit fee, a completed Workers' Compensation Insurance Affidavit, and a copy of your liability insurance in order to receive your license or permit.

The Board of Health office is located at 215B West State Street, Granby, MA 01033
Office hours are Monday – Thursday 9:00a.m. to 3:00p.m., Friday 9:00a.m.-12:00p.m.

Thank you,
Granby Board of Health

Name of Business: _____ Phone: _____
(Print)

Owners Name: _____ Cell: _____
(Print)

Mailing Address: _____

City, State, Zip: _____

Business Address if different from mailing address: _____

SOCIAL SECURITY # OR FID#: _____

INSTALLER'S PERMIT.....$100.00

***ALL ANNUAL PERMITS EXPIRE DECEMBER 31.**
***PAYMENT IS DUE WITH THIS APPLICATION.**
***PLEASE MAKE CHECK PAYABLE TO TOWN OF GRANBY.**

Signature of Owner or Applicant and Title: _____

Date: _____

The undersigned agrees to construct, repair, or pump all sewage disposal systems within the Town of Granby in accordance with the provisions of Title 5 of the Sanitary Code and within the regulations of the Granby Board of Health. No systems shall be constructed, altered or repaired without approval from the Board of Health. The undersigned further agrees that he/she shall have the approved plan in possession at all times and shall be on the premises at the time of final inspection. Any variance of modification of approved plans in the construction or repair of a sewage disposal system without approval of the Board of Health will be cause for revocation or suspension of this permit.