

PERMIT # _____ FEE _____ RECEIVED DATE _____ CHECK # _____



Town of Granby
215B West State Street
Granby, MA. 01033
413-467-7174
413-467-3101 Fax
boh@granbyma.org

Dear Licensee:

YOU MUST COMPLETE, SIGN AND PRESENT OR MAIL THIS FORM WITH YOUR REMITTANCE , A COMPLETED WORKMANS COMP FORM FOR THE STATE, AND A COPY OF YOUR LIABILITY INSURANCE IN ORDER TO RECEIVE YOUR LICENSE/PERMITS. The Board of Health office is located at 215B West State Street, Granby, MA. 01033, and our office hours are Monday – Friday 9:00 a.m. to 1:00 p.m.

Thank you,
Granby Board of Health

Name of Business: _____
(Print)

Phone: _____
Cell: _____

Owners Name: _____
(Print)

Mailing Address: _____

City, State, Zip: _____

Business Address if different from mailing address: _____

INSTALLERS PERMIT.....\$50.00

***ALL ANNUAL PERMITS EXPIRE DECEMBER 31.**

*** PAYMENT IS DUE WITH THIS APPLICATION.**

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.