

TOWN OF LEXINGTON
Community Development
Building Division



The Commonwealth of Massachusetts
 State Board of Regulations and Standards Massachusetts
 State Building Code For One- and Two-Family Dwellings
 8th Edition

APPLICATION FOR: ROOFING, SIDING, WINDOWS

SITE INFORMATION:	Permit # _____ Date issued: _____
	Work approved by: _____
Property Address: _____	Historic District: Yes/ No
Assessors Map/Parcel # _____	

Provide name of Waste/Rubbish hauler: _____ Phone # _____
 Address: _____
 Is this hauler currently permitted through the Health Department? Yes/No Don't know

Roofing 5900: (Note: Roofing is not permitted over more than one (1) existing layer. If two layers of roofing exist, then roof must be stripped before re-roofing.) Roofing shall be installed according to manufacturing recommendations.

Proposed work: Strip and re-roof _____ Re-roof over existing single course _____
 Number of squares _____ Location on roof _____
 Does this involve replacement of sheathing? Yes/No Number of existing layers of roofing? _____

Siding 5700: (Note: Electrical Permit required with application)

Proposed work: Strip & re-side _____ Re-side over existing _____
 Existing material: _____ Proposed material: _____ Electrical Permit: Yes/No

Windows Replacement: (Note: Maximum U .30) Number of replacement windows: _____

Estimated cost of work and material excluding electrical cost: _____

PROPERTY OWNERSHIP/AUTHORIZED AGENT:

Owner of Record: Name (printed) _____	Mailing Address: _____
Signature _____ Phone # _____	
Authorized Agent: Name (printed): _____	Mailing Address: _____
Signature: _____ Phone # _____	

CONSTRUCTION SERVICES:

Licensed Contractor: Name (Printed): _____ Address: _____ Signature: _____ Phone # _____	Not Applicable: _____ License Number _____ Expiration Date _____
Registered Home Improvement Contractor: Company Name: _____ Address: _____ Signature: _____ Phone # _____	Not Applicable: _____ Registration Number _____ Expiration Date _____

Received by/date: _____	Fee: _____	Receipt #: _____	Issued By: _____
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