

Business Trade Name:			
Business Address:			
Business Telephone:			
Applicant Name:	Name of Corporation, Organization, Partnership, or Individual		DOB (if individual)
Applicant Address:	Street Address		City, State Zip
Applicant Telephone:			
Fax:		Email:	

License(s) Applied For—Note: An Additional License Addendum MUST Be Filled Out For Each Specific Business License.

- | | | |
|--------------------------|-------------------------|-----------|
| Alarm | Liquor | Tobacco |
| Amusement | Massage Business | Tree Care |
| Fireworks | Massage Therapist | Other: |
| Gambling—Single Occasion | Solid Waste & Recycling | |
| Lawn Care | Special Event | |

Important

Minnesota Tax ID Number: _____ Federal Employer Identification Number: _____
 The MN Department of Revenue has requested that we provide MN Tax ID and Federal Employer Identification Numbers to them per Minnesota Statute 270C.72. Please enter your numbers above. If you are an individual applicant without a MN Tax ID Number or Federal Employer Identification Number, please enter your Social Security Number or Individual Taxpayer Identification Number here:

I certify that the information provided is true and correct, and hereby agree to operate said business in accordance with the laws of Minnesota and the City Code of the City of Cottage Grove

Applicant Signature and Title: _____ Date: _____

Lawn Care—Commercial License Addendum

Calendar-year License Fee: **\$150.00**

Please make your check payable to *City of Cottage Grove*.

Required Documentation:

1. Fertilizer and Commercial Pesticide Applicators Licenses. Attach a printout from the Minnesota Department of Agriculture website (Fertilizer Companies with Commercial Pesticide Applicators Search – link provided below) showing your company’s Fertilizer License No. and Licensed Commercial Pesticide Applicators, or other proof of your company’s Fertilizer License and Licensed Commercial Pesticide Applicators. If your company does not have a Fertilizer License or Licensed Commercial Pesticide Applicators, please indicate.

http://www2.mda.state.mn.us/webapp/lis/cpestapp_default.jsp

2. Certificate of Liability Insurance. Provide a certificate of insurance covering all operations for the sum of at least one million dollars (\$1,000,000) liability for bodily injuries or death to more than one person from one accident and for at least one million dollars (\$1,000,000) against liability for damage or destruction of property. Policy shall provide that it may not be canceled by the insurer except after ten (10) days' written notice to the city. Certificate Holder should be listed as City of Cottage Grove, 12800 Ravine Parkway, Cottage Grove, MN 55016, cityadmin@cottagegrovemn.gov.



CC0515

Mailing Address:
PO Box 64217
St. Paul, MN 55164-0217

Certificate of Compliance Minnesota Workers' Compensation Law

**THIS FORM MUST BE COMPLETED AND SIGNED
BY ALL BUSINESS TYPES**

E-mail: dli.license@state.mn.us
Web Site: www.dli.mn.gov/ccld.asp
Directions: <http://www.dli.mn.gov/Direct.asp>
Phone: (651) 284-5034

PRINT IN INK or TYPE.

Minnesota Statutes, Section 176.182 requires every state and local licensing agency to withhold the issuance or renewal of a license or permit to operate a business in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, Chapter 176. If the required information is not provided or is falsely stated, it shall result in a \$2,000 penalty assessed against the applicant by the commissioner of the Department of Labor and Industry.

A valid workers' compensation policy must be kept in effect at all times by employers as required by law.

CONTRACTOR'S LICENSE or REGISTRATION NO (if applicable)	BUSINESS TELEPHONE NO.	FAX TELEPHONE NO.
---	------------------------	-------------------

BUSINESS NAME (Use the person(s) name if business structure is sole proprietor or partnership (i.e., John Doe, or John Doe and Jane Doe), otherwise it is the legal name of the business entity.)

DBA NAME (Doing business as name / assumed name – if applicable)

BUSINESS ADDRESS (must be physical street address, no PO boxes)	CITY	STATE	ZIP
COUNTY	E-MAIL ADDRESS		

YOUR LICENSE OR REGISTRATION WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.*

NUMBER 1 – Workers' compensation insurance policy information

INSURANCE COMPANY NAME (not the insurance agent)	NAIC Number	
POLICY NO.	EFFECTIVE DATE	EXPIRATION DATE

NUMBER 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, contact 651.284.5032:

- I have no employees. (See Minn. Stat. § 176.011, subd. 9 for the definition of an employee)
- I am self-insured for workers' compensation (include a copy of authorization to self-insure from the Minnesota Department of Commerce).
- I have employees but they are not covered by the workers' compensation law. (See Minn. Stat. § 176.041 for a list of excluded employees) Explain why your employees are not covered:
- _____
- Other: _____

I certify that the information provided on this form is accurate and complete.

APPLICANT SIGNATURE (mandatory)	TITLE	DATE
---------------------------------	-------	------

NOTE: You must notify us if there is any change to your Workers' Compensation Insurance Information or Employee Status Change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or on a tape. To request, call 1-800-342-5354 (DIAL-DLI) Voice or TDD (651) 297-4198.