MOORHEAD FIRE DEPARTMENT

111 12th Street North, Moorhead, MN 56560
(218) 299-5298 Fax: (218) 299-5072 DD/TTY: 711
www.cityofmoorhead.com

CITY OF MOORHEAD
FIRE PREVENTION BUREAU

TO THE CITY COUNCIL OF THE CITY OF MOORHEAD, CLAY COUNTY, STATE OF MINNESOTA:

THE FOLLOWING BUSINESS IS APPLYING FOR A NEW FIRE PREVENTION PERMIT

OWNER'S NAME: _____

BUSINESS NAME: _____

BUSINESS ADDRESS: _____

MAILING ADDRESS: _____

BUSINESS TELEPHONE: _____

EMAIL ADDRESS: _____

TYPE OF PERMIT: _____

I agree to abide by the Laws, Ordinances, and Regulations pertaining thereto.

Enclosed is my check for _____ in payment of the fee.

Enclosed is my Certificate of Compliance Minnesota Workers' Compensation Law Form

Applicant's Signature_____ **Date** _____

Reset

Certificate of Compliance
Minnesota Workers' Compensation Law

THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT

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.

LICENSE or CERTIFICATE 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 ("doing business as" or also known as an assumed name) (if applicable)

BUSINESS ADDRESS (must be physical street address, no PO boxes)	CITY	STATE	ZIP CODE

COUNTY	E-MAIL ADDRESS

YOUR LICENSE OR CERTIFICATE 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 or 1-800-342-5354.

☐ I have no employees. (See Minn. Stat. § 176.011, subd. 9 for the definition of an employee.)

☐ I am self-insured for workers' compensation (attach a copy of the 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. If I am signing on behalf of a business, I certify that I am authorized to sign on behalf of the business.

PRINT NAME

APPLICANT SIGNATURE (required)	**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.