



Enclosed is an application form for TREE TRIMMING CONTRACTOR'S license in the City of Coon Rapids during the license year 2017.

**PLEASE NOTE:** Companies that provide tree care or tree trimming services and/or who remove trees, limbs, branches, brush or shrubs for hire are required by Minnesota Statutes Chapter 18G.07 to register in Minnesota's Tree Care Registry. The Minnesota Department of Agriculture (MDA) uses this list to keep tree care companies updated on the latest news regarding regulated plant pests in Minnesota. You may register on-line or contact the MDA at 651-201-6611 or email.

Please return the completed application forms with the appropriate license fee and insurance certificate(s) to:

**City of Coon Rapids Forestry  
Attn: Laura  
1831 – 111th Ave. NW  
Coon Rapids, MN 55433-3898**

No license will be issued until all required documents and information are submitted to our office. Also, no work can be done until your license is current.

If you desire further information, please do not hesitate to contact our office.

Sincerely,

Laura LeVasseur  
City Forester's Office  
763-767-6462  
FAX 763-767-6540  
[llevasseur@coonrapidsmn.gov](mailto:llevasseur@coonrapidsmn.gov)

Attachments

**2017 Tree Trimming Contractors License Application  
(EXPIRES DECEMBER 31ST EACH YEAR)**



Applicant (Officer/Owner): Please print name and title

Business Telephone Number

Business Name (DBA)

Street Address

City

State Zip Code

**MINNESOTA TREE CARE COMPANY REGISTRY - License Number**  
(Required by *Minnesota Statutes Chapter 18G.07*)

Names of Employees:

Vehicle/Equipment Type/Description (please list below)

Qty.

License Number

Method and Place of Disposal of Waste Materials:

**OPTIONAL:** Does your staff include a Certified Arborist?

Certificate No.

Expiration Date

**LICENSE REQUIREMENTS:**

1. \$71.00 License Fee (check payable to: City of Coon Rapids)
2. Insurance Certificate for Commercial General Liability Insurance (from insurance company with City of Coon Rapids as certificate holder) at least **\$1,000,000 per occurrence/\$2,000,000 general aggregate**
3. Insurance Certificate for Workers' Compensation (from insurance company with City of Coon Rapids as certificate holder).

**GOVERNMENT DATA PRACTICES ACT-TENNESSEN WARNING**

The data you supply on this form will be used to process the license you are applying for. You are not legally required to provide this data, but we will not be able to process the license without it. The data will constitute a public record if and when the license is granted. I have read and understand the Data Practices Rights Advisory and certify that the statements in this application are true and correct to the best of my knowledge.

**Applicant full name:**

First

Middle

Last

**Signature:**

(Applicant Signature required)

**Date:**

**MINNESOTA WORKERS' COMPENSATION LIABILITY  
CERTIFICATE OF COMPLIANCE**

Minnesota Statute, 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 or engage in an activity in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Chapter 176.181. The information required is: the name of the insurance company, the policy number, and dates of coverage or the permit to self-insure. This information will be collected by the licensing agency and retained in their files.

This information is required by law, and licenses and permits to operate a business may not be issued or renewed if it is not provided and/or is falsely reported. Furthermore, if this information is not provided or falsely stated, it may result in a \$2,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name:

(Name of insurance company not the insurance agent)

Policy Number:

Dates of Coverage:

to

OR

I am not required to have workers' compensation liability coverage because:

I have no employees.

I am self-insured (include permit to self-insure).

I have no employees who are covered by the worker's compensation law (these include: Spouse, Parents, Children and certain farm employees).

Name:

(Last, first, middle)

Doing Business As:

(Business name if different than your name)

Business Address:

Street Address, City, State, Zip

Phone:

I certify that the information provided above is accurate and complete and that a valid workers' compensation policy will be kept in effect at all times as required by law.

Signature:

Date:

Form SP:C1

**LICENSE APPLICANT:**

Pursuant to Minnesota Statute 270C.72 Tax Clearance: Issuance of Licenses, the licensing authority is required to provide to the Minnesota Commissioner of Revenue your Minnesota business tax identification number and the social security number of each license applicant.

Under the Minnesota Government Data Practices Act, we are required to advise you of the following regarding the use of this information:

1. This information may be used to deny the issuance, renewal or transfer of your license in the event you owe the Minnesota Department of Revenue delinquent taxes, penalties or interest;
2. Upon receiving this information, the licensing authority will supply it to the Minnesota Department of Revenue. However, under the Federal Exchange of Information Agreement the Department of Revenue may supply this information to the Internal Revenue Service;
3. Failure to supply this information may jeopardize or delay the processing of your licensing issuance or renewal application.

Please supply the following information and return along with your application to the agency issuing the license. Return to the address listed on the first page of this packet at the City of Coon Rapids, DO NOT RETURN TO THE DEPARTMENT OF REVENUE.

**TYPE OF LICENSE BEING APPLIED FOR OR RENEWED:**

LICENSING AUTHORITY: City of Coon Rapids  
LICENSE RENEWAL DATE: January 1<sup>st</sup> of Each Year

**PERSONAL INFORMATION (if applicable)**

Applicant Name:

Applicant Address:

Street Address City State Zip Code

Social Security Number:

**BUSINESS INFORMATION (if applicable)**

Business Name

Business Address

Street Address City State Zip Code

Minnesota Tax Identification Number Federal Tax Identification Number

If a Minnesota Tax Identification number is not required, please explain on the reverse side.

Signature Position (Officer, Partner, etc.) Date

**AFFIRMATIVE ACTION PROGRAM**

Firm Name:

Phone:

Address:

City

State

Zip Code

Number of Employees:

This Firm is (select below):

Independently Owned and Operated

An Affiliate

Parent Company

or

A Subsidiary

Address

or

Division

Small Business

Large Business

Contractor  
Has

Contractor  
Has Not

Held contracts or subcontractors subject to the Equal Opportunity Clause of Executive Order 11246

Filed the Equal Employment Opportunity Information Report EEO-1 for the period ending March 31 prior

Filed Equal Employment Opportunity Information Report EEO-1 when required

Developed a written Affirmative Action Program

Firm's Equal Employment Opportunity Program Opportunity Compliance Review.

has

has not

been subject to a Government Equal

If so, when:

Signature

Title

Date