

TOBACCO

_____ Complete the following forms:

- 1) City Application “Application for License to sell tobacco, tobacco products or tobacco related devices”
- 2) MN Dept of Revenue Form CT102 “License Application to make retail sales of cigarette and other tobacco products”
- 3) Authorization & Release and NOTARIZE
- 4) Tax Clearance
- 5) Work Comp Form

_____ \$75.00 license fee per year (License Expires 12/31 of every year)

CITY OF BRAINERD

APPLICATION FOR LICENSE TO SELL TOBACCO, TOBACCO PRODUCTS

OR TOBACCO RELATED DEVICES

The undersigned HEREBY MAKES APPLICATION FOR LICENSE TO BE ISSUED TO:

FULL NAME OF APPLICANT: _____

PREVIOUS LAST NAMES OF APPLICANT: _____

APPLICANT'S HOME ADDRESS: _____

NAME OF BUSINESS: _____

BUSINESS ADDRESS: _____

BUSINESS TELEPHONE NUMBER: _____

STORE MANAGER/CONTACT: _____

to sell tobacco, tobacco products or tobacco related devices at retail in the City of Brainerd, in said County and State for the term,

subject to the laws of the State of Minnesota and the ordinances and regulations of said City of Brainerd pertaining thereto and herewith deposit \$75.00 in payment of the fee therefore.

Signature of Applicant Date

Police Chief Signature Date

Fire Chief Signature Date

Council Approval _____ License Number _____ Receipt Number _____

License Application to Make Retail Sales of Cigarette and Other Tobacco Products

To be completed by applicant when applying for a license with a city or county.

Print or type	Applicant's Minnesota tax ID number		The Minnesota tax ID must be issued in the same legal name of the licensee below.		<i>FOR MUNICIPAL USE ONLY</i>		
					License number		
					Period covered		
					Date of issuance		
	<p>Cigarettes/tobacco products will be sold (a separate license is required for each location or vending machine):</p> <input type="checkbox"/> Over counter <input type="checkbox"/> Through vending machine <input type="checkbox"/> Both						
	Licensee's legal name				Federal employer ID number (FEIN)		
	Business trade name (doing business as)				Daytime phone		
Complete address of business location (permit location)				County	Other phone number		
City		State	Zip code		Fax number		
Mailing address (if different than business address)		City	State	Zip code	Email address		

Business information	Type of legal organization (check one):					
	<input type="checkbox"/> Sole proprietor		<input type="checkbox"/> Minnesota corporation: Enter date of incorporation _____			
	<input type="checkbox"/> Partnership		<input type="checkbox"/> Out-of-state corporation: State of incorporation _____			
	<input type="checkbox"/> Other (describe) _____		Are you registered to do business in Minnesota? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Corporate officers or partners (attach a list if necessary)					
Name		Title				
Address		City	State	Zip code		
Name		Title				
Address		City	State	Zip code		

Statement of understanding	As a licensed tobacco products or cigarette retailer, I understand that:				
	1. I can purchase cigarettes only from a Minnesota distributor or subjobber who holds a license with the Minnesota Department of Revenue.				
	2. I must obtain a tobacco products distributor license if I purchase untaxed tobacco products from an out-of-state company.				
	3. I may not sell cigarettes affixed with Minnesota Native American stamps unless my retail business is located on a reservation that has a tax agreement with the State of Minnesota.				
	4. I may not purchase from or exchange cigarettes or tobacco products with another retailer.				
	5. I must keep complete and legible cigarette and tobacco products invoices on the licensed premises, or make invoices available within one hour of request, for at least one year after the date of the purchase.				
	6. I know that the Minnesota Department of Revenue and/or law enforcement may conduct cigarette and tobacco inspections of the premises, including inspections of inventory, invoices and licenses, and I understand that a refusal to allow an inspection is grounds for revocation of my license.				
	7. I know that failure to comply with all requirements can result in criminal penalties, including the loss of cigarettes and tobacco products.				

Sign here	Licensee signature	Title	Print name	Date	Daytime phone
	Licensing agent's signature	Title	Print name	Date	Daytime phone

License applicant: Submit this form to the licensing authority along with the license application.
Licensing authority: Mail or fax a copy of approved form to:
 Minnesota Revenue, Mail Station 3331, St. Paul, MN 55146-3331.

Certificate of Compliance Minnesota Workers' Compensation Law

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 or engage in any activity in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, Chapter 176. The required workers' compensation insurance information is the name of the insurance company, the policy number, and the dates of coverage, or the permit to self-insure. 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.

BUSINESS NAME (Individual name only if no company name used)	LICENSE OR PERMIT NO (if applicable)
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DBA (doing business as name) (if applicable)

BUSINESS ADDRESS (PO Box must include street address)	CITY	STATE	ZIP CODE
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YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. You must complete number 1, 2 or 3 below.

NUMBER 1 COMPLETE THIS PORTION IF YOU ARE INSURED:

INSURANCE COMPANY NAME (not the insurance agent)

WORKERS' COMPENSATION INSURANCE POLICY NO.	EFFECTIVE DATE	EXPIRATION DATE
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NUMBER 2 COMPLETE THIS PORTION IF SELF-INSURED:

I have attached a copy of the permit to self-insure.

NUMBER 3 COMPLETE THIS PORTION IF EXEMPT:

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

- I have no employees.
- 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: _____

ALL APPLICANTS COMPLETE THIS PORTION:

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.

APPLICANT SIGNATURE (mandatory)	TITLE	DATE
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NOTE: If your Workers' Compensation policy is cancelled within the license or permit period, you must notify the agency who issued the license or permit 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.

CITY OF BRAINERD

FORM SP:C1 - TAX CLEARANCE INFORMATION

Pursuant to Minnesota Statute 270.72 Tax Clearance: Issuance of Licenses. The licensing authority is require 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 and the Federal Privacy Act of 1974, 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 only 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 Services :
3. Failure to supply this information may jeopardize or delay the processing of your licensing insurance or renewal application.

Please supply the following information and return along with your application to the agency issuing this license. Do not return to the Department of Revenue.

LICENSE BEING APPLIED FOR OR RENEWED:

LICENSING AUTHORITY: City of Brainerd

LICENSE RENEWAL DATE:

PERSONAL INFORMATION (if applicable):

Applicant's Name _____

Applicant's Address _____

City State Zip Code

Social Security Number _____

BUSINESS INFORMATION (If applicable):

Business Name _____

Business Address _____

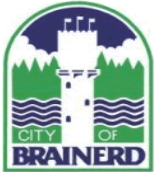
City State Zip Code

Minnesota Tax Identification Number _____

Federal Tax Identification Number _____

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

Signature Position(Officer, Partner, Individual, Etc.)



CITY OF BRAINERD

AUTHORIZATION & RELEASE

The undersigned, having filed an application with the City of Brainerd realizing that the City has need to investigate the background and history of the applicant in order to better evaluate his or her application, does hereby authorize and request every law enforcement official and every other person, firm, officer, corporation, association, organization or institution having control of any documents, records or other information pertaining to me to furnish the original or copies of any such documents, records and other information to the City or any of its representatives and to permit said City or any of its representatives to inspect and make copies of any such documents, records and other information. I further authorize any such persons to answer any inquiries, questions or interrogatories concerning the undersigned which may be submitted to them by the City or its authorized representative. I fully understand that the information so obtained by the City may be used by it in its evaluation of my application.

I hereby release and exonerate any person who shall comply with the authorization and request made herein from any and all liability of every nature and kind growing out of and in any way pertaining to the furnishing or inspection of such documents, records and other information.

Please complete the following information:

Full Name (please print): _____
First Middle Last

Date of Birth: _____

Please list **all** other names you are or have been known by, to include maiden name, previous married names, alias names, and nicknames: _____

Address: _____
Street Address City State Zip

Previous Address: _____
Street Address City State Zip

SIGNATURE OF APPLICANT

DATE

State of _____

County of _____

On _____, _____ personally appeared before me to be the signer of
Date Full Legal Name of Applicant

this document.

Signature of Notary Public

My Commission Expires

(SEAL)