

## New Taxi License

- \_\_\_\_\_ City Application for "Taxicab Certificate Application", signed
- \_\_\_\_\_ Insurance - - - from a Minnesota authorized company in the following amounts must be provided prior to issuing a license: each vehicle authorized in the amount of \$100,000 for bodily injury to one person, in the amount of \$300,000 to injuries to more than one person which are sustained in the same accident and \$50,000 for property damage resulting from any one accident
- \_\_\_\_\_ Every taxicab licensed by the City of Brainerd is required to be inspected upon licensing. Refer to the vehicle inspection form for specific details
- \_\_\_\_\_ Proof of Workers Compensation Insurance coverage form
- \_\_\_\_\_ Tax Clearance information form
- \_\_\_\_\_ Authorization and Release form and NOTARIZE
- \_\_\_\_\_ Proof of Workers' Compensation Insurance Coverage form
- \_\_\_\_\_ \$40 per unit license fee

**TAXICAB CERTIFICATE APPLICATION  
CITY OF BRAINERD**

TO COMPLY WITH THE PROVISIONS OF SECTION 1160 OF THE BRAINERD CITY CODE:

NOTE: License fee is \$40 per year per vehicle (January 1 to December 31). Certificate of Insurance from a Minnesota authorized company in the following amounts must be provided prior to issuing a license: each vehicle authorized in the amount of \$100,000 for bodily injury to one person, in the amount of \$300,000 to injuries to more than one person which are sustained in the same accident and \$50,000 for property damage resulting from any one accident. Every taxicab licensed by the City of Brainerd is required to be inspected upon licensing. Refer to the vehicle inspection form for specific details.

*(please print)*

1. Business Name \_\_\_\_\_
2. Applicant Full Name \_\_\_\_\_
3. Previous Last Names \_\_\_\_\_
4. Date of Birth \_\_\_\_\_
5. Home Telephone Number \_\_\_\_\_
6. Applicant Home Address \_\_\_\_\_
7. Applicant Business Address \_\_\_\_\_
8. Business Telephone Number \_\_\_\_\_
9. Federal Tax Number \_\_\_\_\_ State Tax Number \_\_\_\_\_
10. All unpaid judgments \_\_\_\_\_
11. Years of experience in transporting passengers \_\_\_\_\_
12. List years and names of companies \_\_\_\_\_
13. Number of vehicles to be operated \_\_\_\_\_
14. Color scheme or insignia to designate vehicles \_\_\_\_\_
15. Facts to prove why the public conveniences and necessity call for granting of certificate  
\_\_\_\_\_
16. Other comments or pertinent facts \_\_\_\_\_

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NAME OF COMPANY

SIGNATURE OF APPLICANT

DATE

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CHIEF OF POLICE SIGNATURE

DATE

OFFICE USE

Amount paid \_\_\_\_\_ Date paid \_\_\_\_\_ Receipt No. \_\_\_\_\_ Council Approval \_\_\_\_\_ License \_\_\_\_\_

# 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)

DBA (doing business as name) (if applicable)

BUSINESS ADDRESS (PO Box must include street address)

CITY

STATE

ZIP CODE

**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

**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

**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)