VERIFICATION OF GAS INSTALLER LICENSE
ORDINANCE CODE OF OWATONNA SECTION 477

FEE: $10.00_____
RECEIPT #: _____

STATE OF MINNESOTA
COUNTY OF STEELE

The undersigned hereby applies for a license to carry on the business of Gas Installer in the City of Owatonna in said County and State, subject to the laws of Minnesota and the ordinance of said City.

Name of Applicant _____

Firm Name _____

City of Owatonna Certificate Number _____

Address _____

Telephone _____E-Mail Address:_____

For the period of March 1, 2021 through the last day of February, 2022.

Additional Installers	Certificate Number
_____	_____
_____	_____
_____	_____
_____	_____

State of Minnesota Mechanical Bond No. _MB_____

Insurance Agent _____

Applicant's Signature _____

Dated _____

Remarks_____

_____

_____

VERIFICATION OF GAS INSTALLER LICENSE

CERTIFICATION OF COMPLIANCE
MINNESOTA WORKERS' COMPENSATION LAW

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 a workers' compensation insurance coverage requirement of MSS Chapter 176. 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 $1,000. Penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name: _____
(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 workers' compensation law
(these include: Spouse, Parents, Children, and certain farm employees)

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.

Name: _____
(last, First, middle)

Doing Business As:
_____
(business name if different than your name)

Business Address: _____

City, State, Zip: _____ Phone: (____) _____

Signature: _____ Date: _____