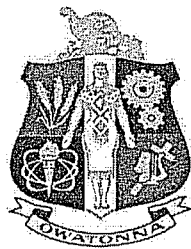


THE CITY OF



OWATONNA

540 West Hills Circle
Owatonna, MN 55060-4794
Ph. (507) 444-4300
FAX: (507) 444-4394

APPLICATION FOR GARBAGE & REFUSE HAULING LICENSE
SECTION 450 OF THE 1992 ORDINANCE CODE OF OWATONNA

STATE OF MINNESOTA
COUNTY OF STEELE

The undersigned hereby applies for a license to carry on the business of collecting, hauling, or disposing of garbage or other refuse in the City of Owatonna in said County and State, subject to the laws of Minnesota and the ordinances of said City.

Name of Applicant _____

Name of Business _____

Address _____

Phone Number _____

For the period of January 1, 2000, through the December 31, 2000.

Fee: _____ (# of vehicles) X \$10.00 = \$_____.

_____ Certificate of Liability Insurance naming City as Additional Insured per Section 450:22.

Signature of Applicant

Date

Fee Paid

Remarks: _____

**-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 the 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: _____