



EDINA HEALTH DIVISION  
 4801 WEST 50<sup>TH</sup> STREET  
 EDINA, MINNESOTA 55424-1394  
 952-826-0370

Office Use Only, Approved by:	
Health: _____	Date: _____
City Clerk: _____	Date: _____

### APPLICATION FOR BUSINESS LICENSE

Name of Establishment: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Establishment Address \_\_\_\_\_ Email: \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Applicant (name of individual, partnership, corporation, LLC) \_\_\_\_\_  
 Applicants Full Address \_\_\_\_\_  
 Owner (if individual) Full Home Address \_\_\_\_\_  
 Contact Person \_\_\_\_\_ Phone \_\_\_\_\_  
 Email: \_\_\_\_\_

**This contact person will receive all legal notices and renewal information. Your entity is responsible for keeping this information current.**

Minnesota Tax ID Number: \_\_\_\_\_ Federal Tax ID Number \_\_\_\_\_

If a Minnesota Tax ID is not required please explain \_\_\_\_\_

Social Security Number (If Applicable) \_\_\_\_\_

If applying on behalf of a partnership, corporation, LLC, or association please list the full name and business address of all partners, all officers and directors as well as shareholders with a 10% or greater interest in the licensed establishment below (Attach additional sheet if necessary.)

Name \_\_\_\_\_ Title \_\_\_\_\_

Business Address \_\_\_\_\_

Name \_\_\_\_\_ Title \_\_\_\_\_

Business Address \_\_\_\_\_

**THE MINNESOTA DATA PRACTICES ACT** requires that we inform you of your rights about the private data we are requesting on this form. Private data is available to you, but not to the public. We are requesting this data to determine your eligibility for a license from the City of Edina. Providing the data may disclose information that could cause your application to be denied. You are not legally required to provide the data, however, refusing to supply the data may cause your license to not be processed. Under MS 270.72, the City of Edina is required to provide the Minnesota Department of Revenue your MN Tax ID Number or Social Security Number. This information may be used to deny the issuance, renewal or transfer of your license if you owe the Minnesota Department of Revenue delinquent taxes, penalties, or interest. The Department of Revenue may supply information to the Internal Revenue Service. In addition, this data can be shared by Edina City Staff, the State of Minnesota Driver License Section, Hennepin County Auditor, Bureau of Criminal Apprehension, Hennepin County Warrant Office, Ramsey County Warrant Office, the Minnesota State Auditor and if required by a court order. Applicant's residence address and telephone number will be considered public data unless you request this information to be private and provide an alternative address and telephone number. Applicant's signature on this application indicates applicant has read and understands their right regarding Data Practices. Please sign below to indicate that you have read this notice:

Signature \_\_\_\_\_

I request that my residence address and telephone number be considered private data. My alternative address and telephone number are as follows:

Address \_\_\_\_\_ Telephone Number \_\_\_\_\_

**Complete all sections applicable to your business:**

**Food Establishments**

Provide name of at least one supervisory employee with a current Certified Food Manager Certificate issued by the Minnesota Department of Health. Attach additional sheets for additional certified staff.

NAME \_\_\_\_\_ EXPIRATION DATE \_\_\_\_\_

**Vending Machines**

Number of Machines	Type of Machine	Location

Attach additional sheets if necessary.

**Amusement Machines**

Provide liability insurance certificate. See Insurance Requirements attached.

Number of Machines	Type of Machine	Location

Attach additional sheets if necessary.

**Swimming Pools and Whirlpools**

Certified Trained Operator Name \_\_\_\_\_ Date Certified \_\_\_\_\_

Pool Address \_\_\_\_\_ Phone \_\_\_\_\_

**Attach a copy of Training Certificate and indicate number of pools.**

\_\_\_ Whirlpool Indoor \_\_\_ Whirlpool Outdoor \_\_\_ Swimming Pool Indoor \_\_\_ Swimming Pool Outdoor

***ABIGAIL TAYLOR POOL SAFETY ACT REQUIRED.***

All public pool owners must certify all outlets except for unblockable drains are equipped with covers that have been stamped by the manufacturer that they are in compliance with ASME/ANSI standards; and all covers and grates, including mounting rings, have been inspected to ensure that they have been properly installed and are not broken or loose.

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**I hereby certify all the information given on this application is complete and accurate.**

\_\_\_\_\_  
**Applicant's Signature**

\_\_\_\_\_  
**Date**

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**FOR CITY USE ONLY:**

**Forms required:** License Fee of \$ \_\_\_\_\_ Workers' Compensation Insurance Proof \_\_\_\_\_

Other \_\_\_\_\_ Database Entry-Date \_\_\_\_\_ **Codes:** 1490.4171 Food

1490.4173 Pool 1490.4170 Tobacco 1490.4172 Vending 1490.4176 Amusement

# 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
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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.