City of Marceline
BUSINESS LICENSE APPLICATION

BUSINESS NAME & MAILING ADDRESS

Names/Address:

_____

_____

Business Type:

Physical Business Address (if different from mailing)

_____

_____

BUSINESS INFORMATION

Home Business? ☐ Yes ☐ No

Property Owner? ☐ Yes ☐ No

Current License? ☐ Yes ☐ No

Business Phone: _____

MO Sales Tax ID: _____

Date Opened: _____

Contact Person of Facility In Charge (name, title, home, address and phone)

General Information

Type of Request ---------- ☐ New Application ☐ Renewal Application

Zoning District: _____

Applicant Certification

I certify the information stated on this application is true and correct to the best of my knowledge. I understand that the City may request substantiation for my claim of any information provided. I agree to comply with the provisions of the City ordinance and all applicable laws. I am aware of the penalties for falsifying information on this application.

_____ Signature _____ Date

Department Certification (Office Use Only)

Application Status Approved Disapproved

Issue Date _____ Expires _____

Fee $_____ Cash Check Other

License #: _____

Staff Signature: _____ Date: _____

Workers' Compensation Insurance

Please read the following carefully to determine if you must comply with Missouri Workers' Compensation Law. After reading the following, please sign the Certificate of Insurance.

Who Must Obtain Workers' Compensation Insurance:

According to Section 287.030.1 (3) of the Revised Statues of Missouri (RSMO), an employer is:

1. Any employer with five or more employee; or
2. Any construction industry employers, who erect, demolish, alter, or repair improvements with one or more employees.

Proof of Workers' Compensation Insurance:

Pursuant to Section 287.061.1 RSMO, any employer who falls into either of the above categories must provide a Certificate of Insurance (see below) to the city or country in which he wishes to obtain an occupational or business license.

Certificate of Insurance

I hereby certify that I have received, read and agree to comply with the State of Missouri's Workers' Compensation Law as set forth above.

Name: _____ Dated: _____

Workers' Compensation Carrier: _____

Effective from: _____ to _____
(Provide Copy to City Hall)

___ My business is not required to have coverage under the Workers' Compensation Law.

Signature: _____ Dated: _____