



# City of East Grand Forks

600 DeMers Ave · P.O. Box 373 · East Grand Forks, MN 56721  
218-773-2483 · 218-773-9728 fax    www.eastgrandforks.net

## APPLICATION FOR SECOND HAND AUTO DEALER LICENSE

License Fee: \_\_\_\_\_

Operating Year: \_\_\_\_\_

### Applicant Information

\_\_\_\_\_  
*Applicant Name*

\_\_\_\_\_  
*Applicant Phone Number*

\_\_\_\_\_  
*Applicant Address*

\_\_\_\_\_  
*City*

\_\_\_\_\_  
*State*

\_\_\_\_\_  
*Zip*

\_\_\_\_\_  
*Length of Time at Present Address*

\_\_\_\_\_  
*Date of Birth*

\_\_\_\_\_  
*Citizenship*

*Addresses and occupations for the three years preceding the date of application:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Names and address of applicant's employers, if any, for the three years preceding the date of application:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*At least 4 character references if applicant has not resided in the City for 2 years next preceding the date of application:*

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*State whether or not applicant has ever been convicted within the last 5 years of any violation of a federal, state, or local law or City Code provision, or other regulation relating to tobacco or tobacco products or tobacco related devices.*

*Date*

*Place of Conviction*

*Nature of Offense*

<i>Date</i>	<i>Place of Conviction</i>	<i>Nature of Offense</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____

City of East Grand Forks  
Application for Second Hand Auto Dealer License

Business Information	
_____	_____
<i>Business Name</i>	<i>Business Phone Number</i>
_____	_____
<i>Business Address</i>	<i>City State Zip</i>
_____	_____
<i>Federal Tax ID #</i>	<i>MN Tax ID #</i>

Corporate Information (if applicable)	
_____	_____
<i>Corporate Name</i>	<i>Phone Number</i>
_____	_____
<i>Corporate Address</i>	<i>City State Zip</i>

I hereby certify that I have completely filled out the entire above application, together and that the application is true, correct, and accurate.

\_\_\_\_\_

*Signature of Applicant*

\_\_\_\_\_

*Date*

\_\_\_\_\_

*Print Name*

\_\_\_\_\_

*Title*

Internal Use Only
The following items need to be completed and/or attached in order for the application to be processed:
*Application fee paid in full: <input type="checkbox"/> yes <input type="checkbox"/> no    Payment Type: <input type="checkbox"/> cash <input type="checkbox"/> check # _____ Receipt # _____
*Application completed in full and signed: <input type="checkbox"/> yes <input type="checkbox"/> no
*Approved <input type="checkbox"/> yes <input type="checkbox"/> no            License Number _____

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**Proof of Workers' Compensation Insurance Coverage**

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 in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Section 176.181, Subd. 2. 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 put in their company file. It will be furnished, upon request, to the Department of Labor and Industry to check for compliance with Minnesota Statute Sec. 176.181, Subd. 2.

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 and/or falsely reported, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry payable to the Special Compensation Fund.

Provide the information specified above in the spaces provided, or certify the precise reason your business is excluded from compliance with the insurance coverage requirement for workers' compensation.

Insurance Company Name: \_\_\_\_\_  
(Not the insurance agent)

Policy Number or Self-Insurance Permit Number: \_\_\_\_\_

Dates of Coverage: \_\_\_\_\_

(Or)

I am not required to have workers' compensation liability coverage because:

( ) I have no employees covered by the law.

( ) Other (specify)

I HAVE READ AND UNDERSTAND MY RIGHTS AND OBLIGATIONS WITH REGARDS TO BUSINESS LICENSES, PERMITS AND WORKERS' COMPENSATION COVERAGE, AND I CERTIFY THAT THE INFORMATION PROVIDED IS TRUE AND CORRECT.

\_\_\_\_\_  
*Signature*