

FIREWORKS FOR DISPLAY OR ENTERTAINMENT PURPOSES PERMIT APPLICATION



CITY OF MOORHEAD
FIRE PREVENTION DIVISION
111 12th Street North, Moorhead, MN 56560
(218) 299-5433 / chad.stangeland@ci.moorhead.mn.us



Date:
Name:
Representing:
Address:
Telephone:
Email Address:

PERMISSION IS HEREBY GRANTED TO CONDUCT FIREWORKS DISPLAY AT:

Street Address:
For Purpose of:

Date and Duration of Display:

Approximate Number, Class and Size of Fireworks to be Used:

Number of Operators or Assistants:

Insurance Liability Company Name:

- Attach copy of policy
Enclosed is my completed and signed Certificate of Compliance Minnesota Workers' Compensation Law Form (Required by Minnesota Statutes, Section 176.182)
Attached is a diagram of fireworks, location including: location of discharge, buildings on site, roads, crowd location, overhead obstructions (trees, utility line, etc.)
I understand that dedicated standby may be required by the authority having jurisdiction, and costs may be associated with dedicated standby.

Approval by Authorized Fire Personnel:

Approved By:

Table with 4 columns: OFFICE USE ONLY, DATE RECEIVED, PERMIT #, DATE ISSUED

Certificate of Compliance Minnesota Workers' Compensation Law

THIS FORM MUST BE COMPLETED BY THE BUSINESS LICENSE APPLICANT

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 in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of Minnesota Statutes, Chapter 176. 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.

LICENSE or CERTIFICATE NO (if applicable)	BUSINESS TELEPHONE NO.	FAX TELEPHONE NO.
BUSINESS NAME (Use the person(s) name if business structure is sole proprietor or partnership (i.e., John Doe, or John Doe and Jane Doe), otherwise it is the legal name of the business entity.)		
DBA ("doing business as" or also known as an assumed name) (if applicable)		
BUSINESS ADDRESS (must be physical street address, no PO boxes)	CITY	STATE ZIP CODE
COUNTY	E-MAIL ADDRESS	

YOUR LICENSE OR CERTIFICATE WILL NOT BE ISSUED WITHOUT THE FOLLOWING INFORMATION. *You must complete number 1 or 2 below.*

NUMBER 1 – Workers' compensation insurance policy information

INSURANCE COMPANY NAME (not the insurance agent)	NAIC Number	
POLICY NO.	EFFECTIVE DATE	EXPIRATION DATE

NUMBER 2 – Reason for exemption from workers' compensation insurance

If you have questions regarding the need to obtain workers' compensation coverage, including exemptions, contact 651.284.5032 or 1-800-342-5354.

- I have no employees. (See Minn. Stat. § 176.011, subd. 9 for the definition of an employee.)
- I am self-insured for workers' compensation (attach a copy of the authorization to self-insure from the Minnesota Department of Commerce).
- 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: _____

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.

PRINT NAME		
APPLICANT SIGNATURE (required)	TITLE	DATE

NOTE: You must notify us if there is any change to your Workers' Compensation Insurance Information or Employee Status Change by resubmitting this form. This material can be made available in different forms, such as large print, Braille or on a tape.