



## CITY OF FOWLER

128 S. 5<sup>th</sup> Street  
Fowler, CA 93625  
(559)834-3113 Fax (559) 834-0185

### BUSINESS LICENSE APPLICATION

BUSINESS NAME: \_\_\_\_\_ BUSINESS PHONE: \_\_\_\_\_

BUSINESS LOCATION: \_\_\_\_\_  
Street Address

City State Zip

MAILING ADDRESS: \_\_\_\_\_  
Street Address

City State Zip

TYPE OF OWNERSHIP:  SOLE PROPRIETOR  PARTNERSHIP  CORPORATION (LIST OFFICERS)

OWNER/CONTACT #1: \_\_\_\_\_ TITLE: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

OWNER/CONTACT #2: \_\_\_\_\_ TITLE: \_\_\_\_\_ PHONE#: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

DESCRIBE BUSINESS: \_\_\_\_\_

FEDERAL TAX ID#: \_\_\_\_\_ STATE TAX ID#: \_\_\_\_\_ SS#: \_\_\_\_\_

STATE BOARD OF EQUALIZATION #: \_\_\_\_\_

STATE CONTRACTOR LIC.#: \_\_\_\_\_ EXP DATE: \_\_\_\_\_

I HAVE employees and maintain Worker's Compensation Insurance as required by Section 3700, California Labor Code.

# of employees: \_\_\_\_\_ WC Carrier: \_\_\_\_\_ Policy #: \_\_\_\_\_ Expires: \_\_\_\_\_

I DO NOT HAVE, or plan to have, employees. Therefore I am not required to maintain Worker's Compensation Insurance.

By signing this form I am confirming that I have verified the information listed. I am aware that my business cannot commence until premises have been inspected by building, fire and community development departments if appropriate. If improper conditions are found they must be corrected prior to opening for business.

Applicant's Signature: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_