

City of Williams
810 E Street / P.O. Box 310
Williams, CA 95987
530-473-2955

**BUSINESS
 LICENSE
 APPLICATION**

NAME OF BUSINESS / DBA:		BUSINESS PHONE:	ANTICIPATED START OF BUSINESS DATE:
BUSINESS STREET LOCATION:	SUITE #:	CITY / STATE	ZIP CODE:
MAILING ADDRESS (IF DIFFERENT):	SUITE #:	CITY / STATE	ZIP CODE
DESCRIBE PROPOSED USE (IN DETAIL)			

SOLE PROPRIETORSHIP	PARTNERSHIP	CORPORATION	LIMITED LIABILITY CORPORATION
BUSINESS OWNER'S NAME	NAMES OF PARTNERS OR OFFICERS		

NOTE: The information above this line will be made public upon request.

BUSINESS OWNER / PARTNER / OFFICER NAME:		OWNER / PARTNER / OFFICER PHONE:	
HOME STREET ADDRESS:		CITY / STATE:	ZIP CODE:
SOCIAL SECURITY #:	FEDERAL EMPLOYER ID #:	STATE EMPLOYER ID #:	STATE BOARD OF EQUALIZATION #:
NUMBER OF FULL TIME EMPLOYEES	STATE CONTRACTORS LICENSE #:	EXPIRATION DATE:	CLASS:

I acknowledge and understand that the Business License Certificate issued by the City of Williams is a receipt evidencing that I have paid the City of Williams business license tax imposed under Chapter 5.04 of the Williams Municipal Code for the year indicated. Issuance of the certificate does not entitle me to carry on the business without complying with all other City building and zoning ordinances and all other applicable laws. I take full and sole responsibility for determining that the business location stated above has the proper zoning and is in the appropriate type of structure, and for securing all necessary approvals prior to commencement of business at this location.

I certify that the above information is true and correct.

SIGNATURE:	TITLE:	DATE:

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WORKERS COMPENSATION DECLARATION

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I hereby affirm, under penalty, ONE of the following declarations:

I have and will maintain a certificate of consent to self-insure for workers' compensation, as provided by Section 3700 of the Labor Code, for the duration of any business activities conducted for which this business license is issued.

I have and will maintain Workers' Compensation Insurance, as required by Section 3700, for the duration of any business activities conducted for which this business license is issued.

My workers' compensation insurance carrier and policy number are:

Carrier: _____

Policy: _____

Business Name: _____

Signature: _____

***** **OR** *****

I certify in the performance of any business activities for which this business license is issued, I shall not employ any person in any manner so as to become subject to the workers' compensation laws of the State of California, and agree if I should become subject to the workers' compensation provisions of Section 3700 of the Labor Code, I shall forthwith comply with the provisions of Section 3700.

Name: _____

Date: _____

Address: _____

Signature: _____

WARNING

Failure to secure workers' compensation coverage is unlawful, and shall subject an employer to criminal penalties and civil penalties up to \$100,000, in addition to the cost of compensation, damages as provided for in Section 3706 of the Labor Code, interest and attorney's fees.