CITY OF DEEPHAVEN
20225 COTTAGEWOOD ROAD
DEEPHAVEN MN 55331
(952) 474-4755

2026 APPLICATION FOR TREE SERVICE LICENSE

I/We, the undersigned, hereby make application for a license to operate a tree trimming/tree removal service in the City of Deephaven. For the purpose of obtaining such license I hereby represent that the following information, as required by ordinance, is true.

This license will expire December 31, 2026

REQUIREMENTS:

1. Application
2. Certification of Compliance Minnesota Worker's Compensation Law **[Form Enclosed]**
3. Insurance: Certificate must name the City as insured.

   $500,000 Injury or death on one person
   $500,000 Injury or death to more than one person / 1 accident
   $100,000 Property damage
4. Fee: **$70.00 = ($50.00 + $20.00 Administration Fee)**

Company Name_____

Address_____City_____

State_____ Zip _____ Phone Number _____

Contractor License Number _____

Minnesota Tax Identification Number_____

Federal or Individual Tax Identification Number_____

Application must be signed with applicant's correct name. If a corporation, that fact must be shown and the officer signing is to show his office. If a partnership, all partner names must appear and at least one partner must sign.

Signed_____

Title _____

Partners _____

OFFICE USE ONLY

Date Received _____ Receipt No. _____

Construction Codes and Licensing Division
Licensing and Certification Services
443 Lafayette Road North
PO Box 64217
St. Paul, MN 55155

E-mail: dli.license@state.mn.us
Website: www.dli.mn.gov
Phone: (651) 284-5034

DEPARTMENT OF LABOR AND INDUSTRY

Certificate of Compliance
Minnesota Workers' Compensation Law

This form must be completed by the business license applicant.

Print in ink or type

Minnesota Statutes § 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 Minn. Stat. 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 number (if applicable)	Business telephone number	Alternate telephone number

Business name (Provide the legal name of the business entity. If the business is a sole proprietor or partnership, provide the owner's name(s), for example John Doe, or John Doe and Jane Doe.)

DBA ("doing business as" or "also known as" an assumed name), if applicable

Business address (must be physical street address, no P.O. boxes)	City	State	ZIP code

County	Email address

You must complete number 1 or 2 below.

Note: You must resubmit this form to the authority issuing your license if any of the information you have provided changes.

1. ☐ **I have a workers' compensation insurance policy.**

Insurance company name (not the insurance agent)

Policy number	Effective date	Expiration date

☐ **I am self-insured for workers' compensation.** (Attach a copy of the authorization to self-insure from the Minnesota Department of Commerce.)

2. I am not required to have workers' compensation insurance because:

☐ I only use independent contractors and do not have employees. (See Minn. Stat. § 176.043 for trucking and messenger courier industries; Minn. Stat. § 181.723, subd. 4, for building construction; and Minnesota Rules chapter 5224 for other industries.)

☐ I do not use independent contractors and have no employees. (See Minn. Stat. § 176.011, subd. 9, for the definition of an employee.)

☐ I use independent contractors and I have employees who are not required to be covered by the workers' compensation law. (Explain below.)

☐ I only have employees who are not required to be covered by the workers' compensation law. (Explain below.) (See Minn. Stat. § 176.041 for a list of excluded employees.)

Explain why your employees are not required to be covered

I certify the information provided on this form is accurate and complete. If I am signing on behalf of a business, I certify I am authorized to sign on behalf of the business.

Print name

Applicant signature (required)	**Title**	**Date**

If you have questions about completing this form or to request this form in Braille, large print or audio.