

# APPLICATION FOR AUCTIONEER'S LICENSE

TO THE COUNTY AUDITOR/TREASURER OF THE COUNTY OF FILLMORE, STATE OF MINNESOTA:

FOR THE PURPOSE OF SECURING A LICENSE TO CONDUCT THE BUSINESS OF AN AUCTIONEER UNDER THE PROVISIONS OF CHAPTER 330, MINNESOTA STATUTES, WITHIN THE STATE OF MINNESOTA, FOR AND DURING THE TERM OF ONE YEAR COMMENCING 20 AND TERMINATING ON 20

THE UNDERSIGNED HEREBY APPLIES FOR AN AUCTIONEER LICENSE AND IN SUPPORT OF THE APPLICATION SUBMITS THE FOLLOWING STATEMENT OF FACTS:

1. Name of Applicant:
2. Applicants Age:                      Date of Birth:
3. Federal/State Tax ID number or SSIF
4. The applicant has been a resident of Fillmore County for at least six months immediately preceding the date of this application and who's current address is:

Wherefore, applicant requests that an Auctioneer License be issued to the undersigned in conformity with the laws, which this license is granted.

Dated: 20

*Applicant Signature*

Subscribed and sworn before me this                      day of                      20

*Signature of Notary Public or Deputy Official*



**- CERTIFICATION OF COMPLIANCE -  
MINNESOTA WORKERS' COMPENSATION LAW**

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 or engage in an activity in Minnesota until the applicant presents acceptable evidence of compliance with the workers' compensation insurance coverage requirement of MSS Chapter 176. 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 retained in their files.

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 or falsely stated, it may result in a \$1,000 penalty assessed against the applicant by the Commissioner of the Department of Labor and Industry.

Insurance Company Name:  
(NOT the insurance agent)

Policy Number:

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

(or)

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

I have no employees

I am self insured (include permit to self-insure)

I have no employees who are covered by the workers' compensation law  
(these include: Spouse, Parents, Children and certain farm employees)

I certify that the information provided above is accurate and complete and that a valid workers' compensation policy will be kept in effect at all times as required by law.

Name:

Doing Business As:

Business name if different than your name

Business Address:

City, State, Zip:

Telephone:

Including area code

Signature:

Type information on the form, then print the form and sign here.

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Date:

Write in date when you sign the form.

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