City of Aurora
16 West 2nd Avenue North
218-229-2614
infor@ci.aurora.mn.us

Tobacco License Application

Name of individual, partnership, LLC, corporation: _____

Owner Information:

Name: _____ Email Address:_____

Owner's Cell Phone: _____ Office Phone: _____

Business Address: _____

Address to Send License: _____

Owner's Birth Date: _____ Driver's License No: _____

Is the applicant 18 years of age or older? ❑ Yes ❑ No

Circle One: Minnesota Tax ID / Federal Tax ID : _____
(Required by the Minnesota Department of Revenue)

Premises Information:

Describe premises to be licensed (type of business): _____

Name of manager _____Phone: _____

Has the applicant, person managing the business, or any person associated in the business ever been convicted of any crime, misdemeanor, or violation of any city, state, or federal law involving activities licensed under this article? ❑ Yes ❑ No
If yes, state the nature of the offense(s) and the punishment or penalty assessed. *Attach additional sheets if necessary.*
_____

I certify the above information is true and correct. Written notice must be provided to the City within five (5) business days following any changes to the information stated above. I acknowledge the provisions of the tobacco and tobacco products ordinance have been reviewed and attest the property at the above address will be operated and maintained according to the requirements of the ordinance, subject to applicable sanctions and penalties. I affirm I will provide all necessary reports and make all sales tax payments as required by State Statute. I affirm I am aware of and will comply with all Federal, State, and Local requirements with respect to tobacco and tobacco products. I authorize the City of Aurora to investigate any or all statements or facts contained herein; acknowledging that the misrepresentation or the omission of facts called for will be just course for the disqualification or repeal of the license.
I understand that as part of the Tobacco License application process, the City shall conduct a criminal background check.

Signature of applicant: _____ Date: _____

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Release of Information for Background Check:
The following named individual has made application with this agency for a Tobacco License.

Last Name of Applicant (please print): _____

First Name (please print): _____

Middle (full)(please print): _____

Maiden, Alias or Former (please print): _____

Date of Birth: _____ **Sex** (M or F): _____
Month/Day/Year

Social Security Number (optional): _____

I authorize the Minnesota Bureau of Criminal Apprehension or East Range Police Department to disclose all criminal history record information to the City of Aurora for the purpose of Tobacco License Application with this agency.
The expiration of this authorization shall be one year from the date of my signature.

MUST BE SIGNED IN FRONT OF A NOTARY

Signature of Applicant_____ **Date**_____

State of Minnesota
County of St. Louis
This record was acknowledged before me on _____(date)
by _____(name(s) of individual(s)).

My commission expires:_____ Stamp:

_____
Notary Signature

For Office Use:

Application Rec'd: _____ Paid: _____ Payment Type: _____

Police Chief Approval:_____Date: _____

Council Approval: _____ License no.: _____ Mailed on: _____

Reason for Denial: _____

DEPARTMENT OF REVENUE

CT102

License Application to Make Retail Sales of Cigarette and Other Tobacco Products

To be completed by applicant when applying for a license with a city or county.

FOR MUNICIPAL USE ONLY

License Authority
License Number
Period Covered
Date of Issuance

Print or Type

Applicant's Minnesota Tax ID Number

The Minnesota Tax ID must be issued in the same legal name of the licensee below.

Cigarettes/tobacco products will be sold *(a separate license is required for each location or vending machine)*:

☐ Over Counter ☐ Through Vending Machine ☐ Both

Licensee's Legal Name				Federal Employer ID Number (FEIN)
Business Trade Name (doing business as)				Daytime Phone
Complete Address of Business Location *(permit location)*		County		Other Phone Number
City		State	ZIP Code	Fax Number
Mailing Address *(if different than business address)*	City	State	ZIP Code	Email Address

Business Information

Type of legal organization *(check one)*:

☐ Sole proprietor
☐ Partnership
☐ Other *(describe)* _____
☐ Minnesota corporation: Enter date of incorporation _____
☐ Out-of-state corporation: State of incorporation _____
Are you registered to do business in Minnesota? ☐ Yes ☐ No

Corporate officers or partners *(attach a list if necessary)*

Name	Title		
Address	City	State	ZIP Code
Name	Title		
Address	City	State	ZIP Code

Statement of Understanding

As a licensed tobacco products or cigarette retailer, I understand that:

1. I can purchase cigarettes and tobacco from a Minnesota distributor or subjobber who holds a license with the Minnesota Department of Revenue. The Cigarette and Tobacco Distributor List is on our website. Go to www.revenue.state.mn.us and type Distributor List in the Search box.
2. I must obtain a tobacco products distributor license if I purchase untaxed tobacco products from an out-of-state company.
3. I may not sell cigarettes affixed with Minnesota Native American stamps unless my retail business is located on a reservation that has a tax agreement with the State of Minnesota.
4. I may not purchase from or exchange cigarettes or tobacco products with another retailer.
5. I must keep complete and legible cigarette and tobacco products invoices on the licensed premises, or make invoices available within one hour of request, for at least one year after the date of the purchase.
6. I know that the Minnesota Department of Revenue and/or law enforcement may conduct cigarette and tobacco inspections of the premises, including inspections of inventory, invoices and licenses, and I understand that a refusal to allow an inspection is grounds for revocation of my license.
7. I know that failure to comply with all requirements can result in criminal penalties, including the loss of cigarettes and tobacco products.

Sign Here

Licensee Signature	Title	Print Name	Date	Daytime Phone
Licensing Agent's Signature	Title	Print Name	Date	Daytime Phone

License applicant: Submit this form to the licensing authority along with the license application.
Licensing authority: Mail, email or fax to:
Minnesota Revenue, Mail Station 3331, St. Paul, MN 55146-3331.
Fax: 651-556-5236. Email: cigarette.tobacco@state.mn.us

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.

Tennessen Warning

In accordance with the Minnesota Government Data Practices Act, Murray County is required to inform you of your rights as they pertain to the private information collected from you. Private data is that information which is available to you, but not to the public. The personal information we collect about you is private.

Minnesota Statutes § 13.01 to § 13.90 on Government Data Practices require that you be informed that the following information which you may be asked to provide on the Application for Employment is considered private data:

1. Name
2. Home address
3. Home telephone number
4. Social Security Number
5. Date of birth
6. Conviction record
7. Sex
8. Age group
9. Disability type
10. Income

We ask this information for the following reasons:

- To distinguish you from all the other applicants and identify you in our personnel files;
- To enable us to verify that you are the individual who makes the application;
- To enable us to contact you when additional information is required, send you notices and/or schedule you for interviews;
- To determine if you meet the minimum age requirements (if any);
- To conduct proper investigations if you are applying for a position;
- To determine whether or not your conviction record may be a job related consideration affecting your suitability for the position you applied for;
- To enable us to ensure your rights to equal opportunity;
- To meet federal and state reporting requirements; and
- To make processing more efficient.

The data supplied by you may be used for such other purposes as may be determined to be necessary in the administration of personnel in Murray County and the policies, rules and regulations promulgated pursuant thereto.

FURNISHING SOCIAL SECURITY NUMBERS, DATE OF BIRTH (unless a minimum age is required), SEX, AGE GROUP, INCOME, AND DISABILITY DATE IS VOLUNTARY, BUT REFUSAL TO SUPPLY OTHER REQUIRED INFORMATION WILL MEAN THAT YOUR APPLICATION MAY NOT BE CONSIDERED.

Private date is available only to you and to other persons in the County Offices who have a bonafide need for the data. Public data is available to anyone requesting it and consists of all data furnished in the application process, which is not designated in this notice as private data.

If you are hired by Murray County, you will be legally required to supply your Social Security number and all applicable tax information. This information will be sent to federal and state tax authorities and to the Social Security Administration, and will enable us to compute your salary deductions. Insurance data which you will be required to furnish in order to participate in County health and life insurance plans will be classified as private as will payroll deductions data.

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In accordance with Minnesota Statutes § 13.03 and § 13.04, I have been informed of and understand my rights as a subject of data.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Co-Applicant Date