



# TOWN OF QUARTZSITE

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## BUSINESS LICENSE RENEWAL FORM

(To ensure proper renewal of your license please fill out this form and return with your payment. Please fill out completely, any blank spaces could result in the return of your payment and delay in processing of your business license. Any payment received without this renewal form will be returned to sender.)

LICENSE NO: \_\_\_\_\_ BUSINESS NAME:DBA: \_\_\_\_\_

BUSINESS LOCATION: \_\_\_\_\_

BUSINESS MAILING ADDRESS: \_\_\_\_\_

BUSINESS OWNERS NAME: \_\_\_\_\_

OWNER'S MAILING ADDRESS: \_\_\_\_\_

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

TYPE OF OWNERSHIP:     \_\_\_ Individual \_\_\_ Partnership     \_\_\_ Corporation

PLEASE LIST NAMES & TITLES OF PERSONS CONNECTED WITH BUSINESS/CORPORATION:

\_\_\_\_\_

MAKE & MODEL OF VEHICLE: (REQUIRED FOR MOBILE BUSINESSES)

\_\_\_\_\_

NATURE OF BUSINESS:   \_\_\_ MANUFACTURING \_\_\_ WHOLESALE \_\_\_ RETAIL \_\_\_ CONTRACTOR \_\_\_ SERVICE

GIVE A BRIEF DESCRIPTION OF BUSINESS:

\_\_\_\_\_

\_\_\_\_\_

NUMBER OF EMPLOYEES TO BE WORKING: (INCLUDING OWNER) \_\_\_\_\_

AZ STATE TRANSACTION PRIVILEGE NUMBER: \_\_\_\_\_

HEALTH PERMIT: \_\_\_\_\_ CONTRACTOR'S LICENSE: \_\_\_\_\_

MEDICAL PROFESSION (DR., NURSES, D.D.S., ETC.) NUMBER: \_\_\_\_\_

I hereby certify that the statements made herein have been examined by me and are, to the best of my belief and knowledge, true and complete.

Signature: \_\_\_\_\_ Date \_\_\_\_\_ Phone# \_\_\_\_\_

Date Rec'd: \_\_\_\_\_ Payment \_\_\_ Cash \_\_\_ Check Ck No. \_\_\_\_\_