

**CITY OF PORT ST. JOE
APPLICATION AND VERIFICATION
OF ZONING FOR BUSINESS TAX**

DATE _____

OWNER/MANAGERS NAME: _____

OWNER/MANAGERS MAILING ADDRESS: _____

TELEPHONE: _____

NAME OF BUSINESS: _____

TYPE OF BUSINESS: _____

BUSINESS ADDRESS: _____

BUSINESS TELEPHONE: _____

EIN/FID# Must be provided _____

AMOUNT OF INVENTORY IF MERCHANT: \$ _____

THE FOLLOWING WILL BE COMPLETED BY ZONING DEPARTMENT:

The above address (is) _____ (is not) _____ zoned for operation of the type of business described herein and (will) _____ (will not) _____ permit operation at that location.

Special conditions that may apply: _____

_____ Does Ordinance No. 234 apply

City Clerk

Date

If this application is approved the requested business license may be issued on or after ten (10) working days from date of application.

Utilities Approved

Code Enforcement Approved