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

DATE __________________

OWNER/MANAGERS NAME: ____

OWNER/MANAGERS MAILING ADDRESS: ___________________________________

____

TELEPHONE: ____

EMAIL ADDRESS: ____

NAME OF BUSINESS: ____

TYPE OF BUSINESS: ____

BUSINESS ADDRESS: ____

BUSINESS TELEPHONE: ____

EIN/FID# Must be provided ____
For information go to https://dos.myflorida.com/sunbiz/start-business/

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**