

CK#3004 \$68.50

LICENSE APPLICATION FOR - ARBORIST
MUNICIPAL CODE SECTION - 4-19

I. APPLICATION TYPE Check One: New _____ Renewal

II. BUSINESS DATA

A. Business Name: Quality Turf Mgmt

B. Business Address: PO Box 855 111 E. 3rd St

City: Mishawaka State: IN. Zip: 46546

C. Mailing Address (If different from above): _____

City: _____ State: _____ Zip: _____

D. Business Telephone Number: 874 310 7837

E. Business Fax Number: _____

F. E-Mail Address: robert@qualityturfmanagement.com

G. Number of Employees: 1

H. Number of Vehicle Plates Needed: 1

I. List Equipment for planting, removing, trimming, spraying, and care of trees and shrubs: _____

shovels, sheers, pruner, saws, axes, chainsaws

J. Do you propagate your own stock? Yes: _____ No:

If No, where is stock purchased: _____

K. Insurance Carrier, Agency, and Amount of Liability Insurance: Liberty Mutual

Will be emailed to you.

L. Type of zoning at the business location: None

For Office Use Only

Application Filed FEB 04 2019 Parks Board Approval _____

Application Fee Paid FEB 04 2019 License Fee Paid FEB 04 2019

Sent to Dept. FEB 04 2019 License Number 19-6477

Plate Number(s) _____

Not Approved _____

Reason _____

Came to your office 1/31/19 to file & pay,
but you were closed.

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III. APPLICANT'S PERSONAL DATA

A. Applicant's Legal Name: Robert Jones
B. Residential Address: 107 Remington Ct. S. Dr Apt D
City: Mish. State: IN Zip: 46545
C. Residential Telephone Number: 300 4339
D. Cellphone Number: _____
E. Position with Business: Owner / Operator

IV. OWNERS PERSONAL DATA

A. Owners Legal Name: Robert Jones
B. Residential Address: 107 Remington S. Dr Apt D
City: Mish State: IN Zip: 46545
C. Residential Telephone Number: 300 4339
D. Cellphone Number: _____
E. Position with Business: Owner / Operator

V. EXPERIENCE / REFERENCES

A. Are you familiar with prevalent tree and shrub diseases and competent to prescribe and apply control measures?

Yes: No: _____ Explain Fully: _____

B. What experience or training in tree surgery have you had?

Explain Fully: None, other than pruning.

C. List below, the names and addresses of not less than four (4) clients where you have recently performed work (include dates):

1: Jeff Billings 4208 Anchor Dr 4/20/18
2: Kim Krystal 4330 "Anchor" Anchor Dr 4/20/18
3: Vicky Pangallo 918 E Mishawaka Ave 9/13/18
4: Donald Decraene 902 W. Grove 9/13/18

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D. Please list all previous employment for three (3) years prior to the date of this application:

Company	Address	City, State, ZIP	Dates
<u>Walmart</u>	<u>316 Indian Ridge</u>	<u>Mish., IN</u>	<u>12/19/18 - Current</u>
<u>Quality Turf Mgmt</u>	<u>Po Box 855 111 E. 3rd St</u>	<u>Mish. IN. 46546</u>	<u>2013 - Current</u>

(Attach additional sheets if necessary)

E. Do you have an International Society of Arboriculture certification?

Yes: _____ No:


If yes, submit a copy of the certification with the application.

VI. INCLUDE CERTIFICATE OF INSURANCE WITH APPLICATION WITH THE CITY OF SOUTH BEND LISTED AS AN ADDITIONAL CERTIFICATE HOLDER

VII. INCLUDE \$5.00 PROCESSING FEE WITH APPLICATION

VIII. AFFIRMATION

I, hereby, certify and affirm that all of the information I have given in this application is true and accurate to the best of my knowledge. I further certify that I have in no way attempted to mislead the City in this application by omitting facts known to me. I agree to permit periodic inspection of my equipment by the Board of Park Commissioners or their agent. I have read and understand the regulations of the Arborist license found in the City of South Bend Municipal Code, Section 4-19.


Signature

1/31/19
Date



CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
02/21/2018

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER JOSE VARGAS INSURANCE AGENCY LLC 4122 W WESTERN AVE SOUTH BEND IN 46819	CONTACT NAME: JOSE VARGAS PHONE (A/C, No, Ext): 674-233-2147 E-MAIL ADDRESS: JOSE@JVARGASINS.COM PRODUCER CUSTOMER ID #:	FAX (A/C, No): 808-451-2227
	INSURER(S) AFFORDING COVERAGE	
INSURED ROBERT JONES QUALITY TURF MANAGEMENT P O BOX 855 MISHAWAKA IN 46546	INSURER A: GRANGE MUTUAL CASUALTY INSURANCE INSURER B: INSURER C: INSURER D: INSURER E: INSURER F:	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS

INSR LTR	TYPE OF INSURANCE	ADDITIONAL INSURANCE	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS
A	GENERAL LIABILITY <input checked="" type="checkbox"/> COMMERCIAL GENERAL LIABILITY <input type="checkbox"/> CLAIMS MADE <input checked="" type="checkbox"/> OCCUR GEN'L AGGREGATE LIMIT APPLIES PER <input type="checkbox"/> POLICY <input type="checkbox"/> PROJECT <input type="checkbox"/> LOC		CT 2066062	02/15/2018	02/15/2019	EACH OCCURRENCE \$ 1,000,000 DAMAGE TO RENTED PREMISES (Ea occurrence) \$ 100,000 MFD EXP (Any one person) \$ 5,000 PERSONAL & ADV INJURY \$ 1,000,000 GENERAL AGGREGATE \$ 2,000,000 PRODUCTS - COMP/OP AGG \$ 2,000,000
	AUTOMOBILE LIABILITY <input type="checkbox"/> ANY AUTO <input type="checkbox"/> ALL OWNED AUTOS <input type="checkbox"/> SCHEDULED AUTOS <input type="checkbox"/> HIRE AUTOS <input type="checkbox"/> NON-OWNED AUTOS					COMBINED SINGLE LIMIT (Ea accident) \$ BODILY INJURY (Per person) \$ BODILY INJURY (Per accident) \$ PROPERTY DAMAGE (Per accident) \$ \$ \$
	UMBRELLA LIAB EXCESS LIAB DEFLECTIBLE RETENTION \$	<input type="checkbox"/> OCCUR <input type="checkbox"/> CLAIMS-MADE				EACH OCCURRENCE \$ AGGREGATE \$ \$ \$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in HI) If yes, describe under SPECIAL PROVISIONS below	<input type="checkbox"/> Y/N N/A				<input type="checkbox"/> WC STATUTORY LIMITS <input type="checkbox"/> OTHER E.L. EACH ACCIDENT \$ E.L. DISEASE - FA EMPLOYEE \$ E.L. DISEASE - POLICY LIMIT \$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)

CERTIFICATE HOLDER DEPARTMENT OF COMMUNITY INVESTMENT 227 W JEFFERSON BLVD SUITE 1400 S SOUTH BEND IN 46601	CANCELLATION SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS. AUTHORIZED REPRESENTATIVE JOSE VARGAS
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