For all municipal business license questions, contact: City of South Bend • Department of Community Investment
227 West Jefferson Blvd • Suite 1400 S •South Bend, Indiana 46601 • 574.235.5912 • F: 574.235.9021

CK 46397 $75.50

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

I. APPLICATION TYPE Check One: **New** _____ **Renewal** ✓

II. BUSINESS DATA

A. Business Name: PROCARE SERVICES INC, DBA LANDMARK LANDSCAPING

B. Business Address: 10882 MCKINLEY HWY

City: OSCEOLA State: IN Zip: 46561

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

City: _____ State: _____ Zip: _____

D. Business Telephone Number: 574-674-8196

E. Business Fax Number: 574-674-6332

F. E-Mail Address: LANDMARKLANDSCAPING88@GMAIL.COM

G. Number of Employees: 8

H. Number of Vehicle Plates Needed: 3

I. List Equipment for planting, removing, trimming, spraying, and care of trees and shrubs:
2 AUGERS, 3 BOBCATS, 1 JOHN DEERE TRACTOR 3 DUMPTKS
MISC SAWS, HANDTOOLS, & ATTACHMENTS

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

If No, where is stock purchased: IN, MICH, OHIO & IL

K. Insurance Carrier, Agency, and Amount of Liability Insurance:
FEDERATED INS & 3,000,000.00

L. Type of zoning at the business location: COMMERCIAL/LIGHT INDUSTRIAL

CONTINUE TO NEXT PAGE

For Office Use Only

Application Filed JAN 0 5 2022 Parks Board Approval _____
Application Fee Paid JAN 0 5 2022 License Fee Paid JAN 0 5 2022
Sent to Dept. JAN 0 5 2022 License Number ARB2022-002
Plate Number(s) _____

Not Approved _____
Reason _____

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

III. APPLICANT'S PERSONAL DATA

A. Applicant's Legal Name: STEVEN JAMES SOLLIDAY

B. Residential Address: 14776 WHEATON DR.

City: GRANGER State: IN Zip: 46530

C. Residential Telephone Number: NONE

D. Cellphone Number: 574-340-8767

E. Position with Business: PRESIDENT

IV. OWNERS PERSONAL DATA

A. Owners Legal Name: SAME AS ABOVE

B. Residential Address: _____

City: _____ State: _____ Zip: _____

C. Residential Telephone Number: _____

D. Cellphone Number: _____

E. Position with Business: _____

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: 3A 3B LICENSES

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

Explain Fully: PURDUE & INDIANA STATE CHEMISTY
OVER 20 YEARS PRACTICAL EXPERIANCE

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

1: PORTAGE PRAIRIE SPEC 4-5565 N. DYLAN DR, South BEND, IN
2: NFI - 5750 BRICK RD, South BEND, IN.
3: DRIVE & SHINE 2046 So BEND AVE, South BEND, IN
4: GATES BODY Shop 705 W. IRELAND RD, South BEND, IN

CONTINUE TO NEXT PAGE

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

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

Company	Address	City, State, ZIP	Dates
Self Employed NONE	NONE	NONE	NONE

(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.

Steve Sallday
Signature

1-3-22
Date

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 11/02/2021

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 have ADDITIONAL INSURED provisions or 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
FEDERATED MUTUAL INSURANCE COMPANY
HOME OFFICE: P.O. BOX 328
OWATONNA, MN 55060

CONTACT NAME: CLIENT CONTACT CENTER
PHONE (A/C, No, Ext): 888-333-4949 **FAX (A/C, No):** 507-446-4684
E-MAIL ADDRESS: CLIENTCONTACTCENTER@FEDINS.COM

INSURER(S) AFFORDING COVERAGE	NAIC #
INSURER A: FEDERATED MUTUAL INSURANCE COMPANY	13935
INSURER B:	
INSURER C:	
INSURER D:	
INSURER E:	
INSURER F:	

INSURED 377-109-4
PROCARE SERVICES, INC., LANDMARK LANDSCAPING
10882 MCKINLEY HWY
OSCEOLA, IN 46561-9784

COVERAGES **CERTIFICATE NUMBER: 44** **REVISION NUMBER: 0**

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	ADDL INSR	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
A	X COMMERCIAL GENERAL LIABILITY CLAIMS-MADE X OCCUR GEN'L AGGREGATE LIMIT APPLIES PER: X POLICY PRO-JECT LOC OTHER:	N	N	6142727	04/01/2021	04/01/2022	EACH OCCURRENCE DAMAGE TO RENTED PREMISES (Ea occurrence) MED EXP (Any one person) PERSONAL & ADV INJURY GENERAL AGGREGATE PRODUCTS - COMP/OP AGG	$1,000,000 $100,000 EXCLUDED $1,000,000 $2,000,000 $2,000,000
A	AUTOMOBILE LIABILITY X ANY AUTO OWNED AUTOS ONLY SCHEDULED AUTOS HIRED AUTOS ONLY NON-OWNED AUTOS ONLY	N	N	6142727	04/01/2021	04/01/2022	COMBINED SINGLE LIMIT (Ea accident) BODILY INJURY (Per person) BODILY INJURY (Per accident) PROPERTY DAMAGE (Per accident)	$1,000,000
A	X UMBRELLA LIAB X OCCUR EXCESS LIAB CLAIMS-MADE DED RETENTION	N	N	6142728	04/01/2021	04/01/2022	EACH OCCURRENCE AGGREGATE	$3,000,000 $3,000,000
A	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y/N ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH) If yes, describe under DESCRIPTION OF OPERATIONS below	N/A	N	1812526	04/01/2021	04/01/2022	X PER STATUTE OTH-ER E.L. EACH ACCIDENT E.L. DISEASE - EA EMPLOYEE E.L. DISEASE - POLICY LIMIT	 $1,000,000 $1,000,000 $1,000,000

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

CERTIFICATE HOLDER

377-109-4 44 0
CITY OF SOUTH BEND
DEPARTMENT OF COMMUNITY INVESTMENT
227 W JEFFERSON BLVD STE 1400S
SOUTH BEND, IN 46601-1830

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
Michael G Kerr