



# Borough Of Lansdowne

12 East Baltimore Avenue  
Lansdowne, PA 19050  
(610) 623-7300  
Fax: (610) 623-5533

Jayne C. Young  
Mayor

## Contractor's Registration Effective January 1

Date: \_\_\_\_\_

The undersigned hereby registers to work in the Borough of Lansdowne, PA for the fiscal year beginning January 1.

Owner(s) Name \_\_\_\_\_  
(Partners, Directors, Officers)

Business/Trade Name: \_\_\_\_\_

Type of Trade : \_\_\_\_\_  
(roofer, general contractor, landscaper, electrician, paver, concrete, etc)

Business Address: \_\_\_\_\_

Business Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Applicant's Signature: \_\_\_\_\_

Approved: \_\_\_\_\_ License Number CL- \_\_\_\_\_ - \_\_\_\_\_

Has the applicant had a similar contractor's license refused or revoked by any municipality within two years of the application? [ ] YES [ ] NO

If Yes, please explain in writing the reasons for same: \_\_\_\_\_

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**INSURANCE REQUIREMENT:** No contractor's license shall be issued unless the applicant files a certificate of insurance and worker's compensation coverage with the inspector at the time of the license application. The certificate of insurance and worker's compensation coverage shall contain a provision that coverage afforded under the policy will not be cancelled until at least fifteen (15) day's prior written notice of such cancellation has been given to the Borough. The certificate of insurance must evidence policies of insurance for public liability, property damage, product liability and completed operations, each of which must have a single occurrence limit of at least \$300,000.

**FEE:** \$85.00 if registered after February 1 each year  
\$10.00 for each additional employee

(Over Please)→

# WORKERS COMPENSATION INSURANCE COVERAGE INFORMATION

- A. Is the applicant a contractor within the meaning of the Pennsylvania Workers Compensation Law?

[ ] YES [ ] NO

If YES, complete Sections B and C only

If NO, complete Section D only

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**B. Insurance Information:**

Name of Applicant: \_\_\_\_\_

Federal or State Employer Identification Number: \_\_\_\_\_

**C. Workers Compensation Information:**

Applicant is a qualified self-insurer for workers compensation. Attach certificate.

Name of Workers Compensation Insurer: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Expiration Date: \_\_\_\_\_

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D. Signature of Applicant: \_\_\_\_\_

Title: \_\_\_\_\_

Business Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_

Date: \_\_\_\_\_