

SECTION C: WORKER COMPENSATION/DISABILITY INSURANCE INFORMATION

This is to certify, under penalties of perjury, that the above described operation has Worker’s Compensation and Disability Coverage when required by law OR that the Worker’s Compensation Board has issued Form CE-200 stating that such coverage is not required.

_____	_____	_____
Worker’s Compensation Carrier	W.C. Policy #	Expiration Date
_____	_____	_____
Disability Benefits Carrier	D.B. Policy #	Expiration Date

Date of Form CE - 200 Exemption		

CERTIFICATION: To be signed by Applicant, Owner/Operator or Corporate Officer

_____	_____
Name of person completing this application	Title

I certify that the information provided on this application is true.
False statements on this application are punishable under Penal Law.

_____	_____
Signature of Applicant	Date

_____	_____
Signature of Studio Owner/Operator or Corporate Officer	Date

For Office Use Only

Required documents submitted Yes Date _____ No

Conditions of Approval _____

Approved By _____	_____	_____
Signature	Title	Date