

**TOWN OF SURFSIDE
BUILDING DEPARTMENT**
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A Uj: 305.861.4863, Fax: 305.861.1302`

Contractor Registration/Renewal Requirements

The following documents need to be submitted along with the contractor registration form to buildingapp@townofsurfsidefl.gov

Annual Registration is due every Fiscal Year: October-September

Miami-Dade County Contractors:

- U Certificate of Competency. (Front and Back)
- V State of Florida Registration (If holding a Master License.)
- W Liability and Worker's Compensation Certificate(s) of Insurance, addressed to the Town of Surfside.
- X A copy of the Qualifiers Driver's License.
- Y Miami-Dade County Local Business Tax Receipt (L.B.T.R)

State Contractors:

- U State License
- V Liability and Worker's Compensation Certificate(s) of Insurance, addressed to the Town of Surfside.
- W A copy of the Qualifier's Driver License.
- X Local Business License.

We will no longer accept faxed licenses; originals must be submitted in person or by email.

I authorize the following individual(s) to pickup plans and permit documents on my behalf:

Name of Individual	Driver's license Number
1. _____	_____
2. _____	_____

Name of Contracting Firm (Print)	Sworn to and subscribed before me this day of _____ 20____
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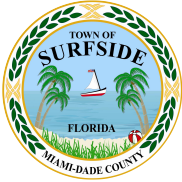
Qualifier's Signature	Print or type name of notary
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Qualifier's Name (Print)	Notary Signature
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Business Address (Print)	My Commission expires:
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Business Phone Number	<input type="checkbox"/> Personally, known to me, or
	<input type="checkbox"/> Produced identification, type:

Cell Phone Number



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A ~~U~~ ~~b~~ ~~:~~ 305.861.4863, Fax: 305.861.1302

Company Name: _____

Company Address: _____

City _____ State _____ Zip Code _____

Company Telephone: () _____ - _____

Company Fax: () _____ - _____

Qualifier Name: _____

Qualifier Address: _____

City _____ State _____ Zip Code _____

Qualifier Telephone: () _____ - _____

E-mail Address: _____

State License: _____ Expiration: ____/____/____

Municipal License: _____ Expiration: ____/____/____

Liability Insurance Company: _____ Expiration: ____/____/____

Policy Number: _____

Workers Comp. Insurance Company: _____ Expiration: ____/____/____

Policy Number: _____

OFFICE USE ONLY:

Date Received: _____ Data Base Entry Date: _____

Insurance Verified: _____ Amount Paid: _____

Clerk Initial: _____ Comments: _____

RENEWAL MUST BE DONE BY SEPTEMBER 30 OF EACH YEAR