

# SIoux FALLS HEALTH DEPARTMENT

## **Pest Control Agency—Permit Application**

**Annual Fee—\$24**

---

### **Establishment Information:**

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Manager's Name: \_\_\_\_\_

---

### **Billing Information:**

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

---

### **Owner Information:**

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Fee Amount Remitted: \$ \_\_\_\_\_ Date Paid: \_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

Liability insurance has been furnished as follows: \_\_\_\_\_

**Make checks payable to:** City of Sioux Falls

**Submit payment to:** Sioux Falls Health Department  
521 North Main Avenue, Suite 101  
Sioux Falls, SD 57104-5963

**Office Use Only**

Clerk: \_\_\_\_\_

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

Total remitted: \$ \_\_\_\_\_

Receipt No.: \_\_\_\_\_

