



APPLICATION FOR EMPLOYMENT AGENCY LICENSE
 (Answer All Questions On Both Sides - Attach Additional Sheets If Necessary)

1 A. NAME UNDER WHICH AGENCY WILL DO BUSINESS	1B. MAIN TYPE OF PLACEMENTS	1C. FEIN	2. BUSINESS TELEPHONE (AREA CODE AND NUMBER)
3. ADDRESS WHERE AGENCY WILL BE LOCATED	CITY-TOWN-VILLAGE	COUNTY	ZIP CODE

OWNER (CHECK ONE) <input type="checkbox"/> SOLE PROPRIETOR <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> CORPORATION	5. Total number of anticipated placement employees: _____
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6. Name and address of owner if sole proprietor; or each partner if partnership; or all officers if corporation, and each stock-holder owning 10% or more stock if not publicly traded.

NAME AND HOME ADDRESS	TITLE	HOME TELEPHONE

7. State all business activities engaged in by the above named persons for the five years preceding the date of application.

NAME OF PERSON	NAME AND ADDRESS OF FIRM	ACTIVITY	DATE STARTED	DATE ENDED

8A. For any person listed in item 6, was any license to conduct a business ever denied, cancelled, suspended, revoked, or surrendered? Yes No If "Yes", give details and reasons in item 8B.

8B. Details of Denial, Cancellation, Etc.

NAME OF PERSON	DATE OF ACTION	NAME AND ADDRESS OF BUSINESS (City - Town - Village - State)	NATURE OF BUSINESS	REASON FOR DENIAL, ETC.

9. Was any person listed in item 6 ever convicted of any crime or offense other than a traffic infraction?
 Yes No If "Yes", give details and reasons in item 8B.

NAME OF PERSON	OFFENSE	DATE CONVICTED	CITY - TOWN - VILLAGE	PENALTY

10A. Name of person who will direct and operate the placement activities of the agency

IF THIS PERSON IS NOT LISTED IN ITEM 6, AN "APPLICATION FOR AGENCY MANAGER PERMIT"
 MUST BE REQUESTED AND ITEM 10B (ON REVERSE) NEED NOT TO BE ANSWERED.

(COMPLETE ALL ENTRIES ON REVERSE)

10B. List each employer for whom person listed in item 10A worked as a placement employee, vocational counselor, or in related activities. Include self-employment. Give the length of time worked for each employer and the duties performed for each. List last employer first.

NAME AND ADDRESS	DATE STARTED	DATE ENDED	DUTIES (give detailed listing, showing percent of time spent at interviewing and counseling applicants; screening, selecting and placing applicants; soliciting and obtaining job orders; preparing job descriptions, etc. and time spent on non-related placement duties; give name and title of immediate supervisor.)

11. Does applicant intend to recruit persons from outside the State for employment as domestic or household employees?
 Yes No If "Yes", give details regarding each emigrant agent. Submit photostatic copy of each licensed agent's license.

NAME AND ADDRESS OF EMIGRANT AGENT	STATE (Country If not U S) IN WHICH OPERATING	LICENSE NUMBER	DATE LICENSE EXPIRES	NAME, ADDRESS, TITLE OF ISSUING OFFICIAL

12. Does applicant intend to provide or arrange for lodging for applicants for employment or for person doing business with the agency? Yes No If "Yes", give details regarding each location.

NAME AND ADDRESS OF PREMISES WHERE LODGING WILL BE FURNISHED	TELEPHONE NUMBER	NAME OF PERSON IN CHARGE

13. Does applicant provide hospitalization insurance for overseas domestics? Yes No If "Yes", give name of insurance company and policy number.

NAME OF INSURANCE COMPANY	POLICY NUMBER

NOTE

Application must be accompanied by: (a) surety bond naming the people of the State of New York as obligee, in the penal sum of \$5,000, except penal sum of \$10,000 required for modeling agencies and agencies engaged in recruiting domestic or household employees from outside the continental United States; (b) completed fingerprint card(s) for each person listed in item #6 of this application; (c) two statements of character for each person listed in item #6 of this application; (d) check or money order for the required fee, payable to the Commissioner of Labor; (e) separate U.S. \$75.00 certified check or postal money order only for the required fingerprint search and verification (\$75.00 for each search), payable to the New York State Division of Criminal Justice Services (Note: No personal checks will be accepted); (f) two samples of each form that applicants will be required to sign (g) photocopies of each licensed emigrant agent's license; (h) if sole owner or partnership, certified copy of certificate of doing business as filed with the county clerk. If corporation, photocopy of corporate filing receipt as filed with Secretary of State; (i) **FROM YOUR INSURANCE COMPANY**, you must obtain a completed C-105.2 proving worker's compensation insurance coverage and a completed DB-120.1 proving disability insurance coverage, and provide them to this office. Other acceptable forms of proof: U-26.3 from SIF; or, if self-insured SI-12 or GSI-105.2 for WC and DB-155 for disability.

If **not** liable for WC and/or disability insurance, provide completed WC/DB-100 (Replaces C-105.21 form) to this office. This form is available at www.wcb.state.ny.us under "Common Forms On-Line". You may contact the Workers' Compensation Board at (518) 474-6967 for assistance in obtaining this form; when calling, wait after the menu finishes for someone to give you assistance; (j) if corporation, conformed or photocopy of corporate minutes showing election of officers.

IMPORTANT PROMPT NOTIFICATION REQUIRED OF ANY CHANGE OF AGENCY NAME, ADDRESS, MANAGER OWNERSHIP, PARTNERS, OFFICERS OR STOCKHOLDERS. PRIOR APPROVAL WILL BE REQUIRED.

THE STATEMENTS MADE IN THIS APPLICATION ARE SUBSCRIBED AND AFFIRMED BY ME AS TRUE UNDER THE PENALTIES OF PERJURY.

14. Signature of owner. If a corporation, must be signed by president and treasurer; if a partnership, by all partners.

SIGNATURE(S) OF PERSON(S) MAKING APPLICATIONS	TITLE	DATE

ALL INFORMATION AND MATERIAL SUBMITTED IS SUBJECT TO INVESTIGATION BY THIS DEPARTMENT