APPLICATION FOR BUSINESS TAX FEE EXEMPTION

City of Bunnell, Office of the City Clerk
PO Box 756, Bunnell, FL 32110
Phone: (386)437-7500 x 5

Applicant Information:

_____

Name Street Address City, State Zip Code

Applicant claims exemption from the business tax for the privilege of engaging in the business/occupation of:

_____

located at: _____

I, _____ (PRINT NAME OF APPLICANT)
as authorized representative of _____(PRINT BUSINESS NAME) do hereby certify that the business for which I am applying meets the Florida State Statute requirements for a business tax fee exemption in accordance with the item checked below, and I do hereby apply for the same.

☐ **DISABLED PERSON:** I am a physically disabled person, incapable of manual labor, **AND** I do not have more than one employee **AND** I use my own capital only, which does not exceed one thousand dollars ($1,000.00)
(F.S. 205.162 - Physician Certificate of Disability from performing manual labor required.)

☐ **AGE 65 OR OLDER:** I am sixty-five (65) years of age or older **AND** I do not have more than one (1) employee **AND** I use my own capital only, which does not exceed one thousand dollars ($1,000.00) (F.S. 205.162 – Florida Drivers License OR other proof of age required.)

☐ **WIDOW / WIDOWER:** I am a person who is a widow / widower with minor dependent(s) **AND I** do not have more than one employee AND I use my own capital only, which does not exceed one thousand dollars ($1,000.00)
(F.S. 205.162 - Proof of the right to the aforesaid required.)

☐ **HONORABLY DISCHARGED VETERAN:** I am a Veteran of the United States Armed Forces who was honorably discharged upon separation from service, or the spouse or un-remarried surviving spouse of such a veteran (F.S. 205.055) **AND** I own a majority interest in a business with fewer than 100 employees. (Proof of the right to the aforesaid required.)

☐ **SPOUSE OF ACTIVIE DUTY SERVICE MEMBER:** I am the spouse of an active duty military servicemember who has relocated to the municipality pursuant to a permanent change of station order (F.S. 205.055) **AND** I own a majority interest in a business with fewer than 100 employees. (Proof of the right to the aforesaid required.)

☐ **PUBLIC ASSISTANCE:** I am a person who is receiving public assistance as defined in F.S. 409.2554, (F.S. 205.055) **AND** I own a majority interest in a business with fewer than 100 employees. (Proof of the right to the aforesaid required.)

☐ **HOUSEHOLD INCOME BELOW FEDERAL POVERTY LEVEL:** I am a person whose household income is below 130 percent of the federal poverty level based on the current year's federal poverty guidelines (F.S. 205.055) **AND** I own a majority interest in a business with fewer than 100 employees. (Proof of the right to the aforesaid required.)

☐ **CHARITABLE OPERATION:** is a charitable, religious, fraternal, youth, civic, service, or other similar organization that makes occasional sales or engages in fundraising projects that are performed exclusively by the members, and the proceeds derived from the activities are used exclusively in the charitable, religious, fraternal, youth, civic, and service activities of the organization. (F.S. 205.192 tax exempt information required)

☐ **FARMING:** is engaging in the selling of farm, aqua cultural, grove, horticultural, floricultural, tropical pisciculture, or tropical fish farm products, or products manufactured therefrom, when such products were grown or produced by such person in the state. (F.S. 205.064)

I affirm that I am not engaged in the sale of intoxicating liquors or malt and vinous beverages.

I declare under penalty of perjury that the foregoing is true and correct.

_____ _____

Signature of Applicant Date

Effective 8/2021

PHYSICIAN'S CERTIFICATE

STATE OF FLORIDA

COUNTY OF _____

I _____, hereby certify that I am a licensed practicing physician, located at _____and that I am personally acquainted with _____who is the applicant for exemption from payment of the business tax under the provisions of Section 205.162, Florida Statutes, and that I have thoroughly examined the said applicant and found him/her to be physically disabled and unable to perform manual labors as means of livelihood as stated in the application of which this certificate is a part, the nature of the disability being as follows:

_____

_____

_____

_____

_____

_____

Physician's Signature Date