FIRST NATION MEDICAL BOARD

Application for Tribal Business License

Business Information

Date:_____

Business Name:_____

Business Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

Website Address:_____ Email:_____

Type of Business: ☐ Sole Proprietorship ☐ Corporation ☐ Limited Liability Company
☐ Partnership ☐ Limited Partnership

Business TIN:_____

Business d/b/a:_____

Owner Contact #1

Owner Name:_____ Title:_____

Owner Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

Email:_____ % Ownership:_____

Owner Contact #2

Owner Name:_____ Title:_____

Owner Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Fax Number:_____

Email:_____ % Ownership:_____

Authorized Contact

First Name:_____ Middle Initial:_____ Last Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone Number:_____ Cell Number:_____

Email:_____ Fax Number:_____

Questions

1. Describe all Business Activity:_____
   _____
2. Date your business started at this location:_____
3. Date your business began operating:_____
4. Number of employees:_____
5. Square footage of the premises:_____

Statements

By checking this box I am agreeing to: ☐

- abide by all the terms and conditions listed herein;
- provide a current credit card on file for annual renewal; and
- pay a tribal donation fee of five percent (5%) on gross receipts for all goods and services.

All information I have provided by me herein is true and complete to the best of my knowledge: ☐

Payment
($200)

Credit Card ☐ Debit Card ☐ Check ☐

Credit Card Type: VISA ☐ MASTERCARD ☐ DISCOVER ☐ AMEX ☐
Credit Card Number:_____
Expiration:_____ Security Code:_____

Debit Card Number:_____
Expiration:_____ Security Code:_____

I understand and agree that payment must accompany my FNMB Business License submission form, my application will not be reviewed until it is complete, payment is no guarantee it will be approved, there is an administration fee to review my application, and in the event my application is not approved 50% (fifty percent) of my application fee will be refunded. Cancellation must be done with written notice 30 days prior to annual renewal.

_____
Signature

MAIL THIS FORM TO:

First Nation Medical Board
2121 E. Flamingo Road, Suite 112
Las Vegas, Nevada 89119

EMAIIL THIS FORM TO:

info@firstnationmedicalboard.com

FAX THIS FORM TO:

(702) 902-2862