

Fee Pd. \_\_\_\_\_

Application No. \_\_\_\_\_

**APPLICATION FOR CERTIFICATE OF COMPLIANCE  
CITY OF PATASKALA**

The applicant will submit a copy of this form, along with supplementary information to the Zoning Inspector for the City of Pataskala. For further information related to the application process, please refer to Chapter 1209, Enforcement and Penalty of the City of Pataskala Codified Ordinance. Application shall include fee as specified by the City Ordinance.

1. Name of Applicant: \_\_\_\_\_

2. Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_ (Cell) \_\_\_\_\_  
(Fax) \_\_\_\_\_ (Email) \_\_\_\_\_

3. Name of Property Owner: \_\_\_\_\_

4. Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Business) \_\_\_\_\_ (Cell) \_\_\_\_\_  
(Fax) \_\_\_\_\_ (Email) \_\_\_\_\_

5. Address/Location of Property: \_\_\_\_\_

6. Attach Legal Description of the property: \_\_\_\_\_

7. What is the existing Zoning District: \_\_\_\_\_

8. What is proposed use of property: \_\_\_\_\_

9. Indicate whether this is a new or existing structure \_\_\_\_\_

10. Attach approval by Licking County Health Department, if not by public water and/or sewer.

NOTE: All new businesses must request an inspection from the West Licking Joint Fire District: (740) 927-8600

I certify that the exterior erection and/or structural alterations of the building have been completed in conformance with the provision of the Zoning Ordinance.

\_\_\_\_\_  
APPLICANT

\_\_\_\_\_  
DATE

**FOR INTERNAL USE ONLY**

APPROVED \_\_\_\_\_ DISSAPROVED \_\_\_\_\_

REMARKS \_\_\_\_\_

DATE OF DECISION \_\_\_\_\_

ZONING INSPECTOR \_\_\_\_\_

Distribution: Applicant – White    Zoning Inspector – Canary    City of Pataskala - Pink



Planning & Zoning Department  
621 West Broad Street  
Pataskala, Ohio 43062-0302  
(740) 927-4910 (Office) (740) 964-6269 (Fax)

The following information is requested and please attach to the application:

\_\_\_\_\_  
Parcel Number(s)

\_\_\_\_\_  
Proposed Use

\_\_\_\_\_  
Old Use

\_\_\_\_\_  
Number of Employees

\_\_\_\_\_  
Proposed Activities

\_\_\_\_\_  
Days and Hours of Operation

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

\_\_\_\_\_  
Date

FEDERAL IDENTIFICATION NUMBER \_\_\_\_\_

SOCIAL SECURITY NUMBER (COMPLETE ONLY IF A SOLE PROPRIETOR) \_\_\_\_\_

FILING STATUS:  CORPORATION  ESTATE/TRUST  LLC  NON-PROFIT  PARTNERSHIP  S-CORP.  SOLE PROPRIETOR

**RITA LOCATION NAME AND ADDRESS AS USED FOR BUSINESS PURPOSES**

BUSINESS NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**IF CORPORATE SUBSIDIARY, GIVE NAME AND ADDRESS OF PARENT COMPANY MAIN OFFICE**

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**IF SOLE PROPRIETORSHIP, GIVE OWNER'S NAME AND HOME ADDRESS**

NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

WHAT DATE DID YOU BEGIN OPERATIONS IN A RITA MUNICIPALITY \_\_\_\_\_

**PLEASE LIST THE COMPANY NAICS CODE OR CHECK THE BOX THAT BEST DESCRIBES THE COMPANY BUSINESS TYPE**

NAICS \_\_\_\_\_  TRANSPORTATION  NON MANUFACTURING  MANUFACTURING  WHOLESALE  
 RETAIL  FINANCE  SERVICES  PUBLIC ADMINISTRATION  NON CLASSIFICATION

**EMPLOYEE INFORMATION**

DO YOU HAVE ANY EMPLOYEES? (CHECK ONLY ONE)  YES  NO ARE CONTRACTORS UTILIZED? (CHECK ONLY ONE)  YES\*  NO  
\*IF YES COMPLETE REVERSE SIDE.

IF YOU HAVE EMPLOYEES PROCEED WITH EMPLOYEE INFORMATION. IF YOU DO NOT HAVE EMPLOYEES PROCEED TO THE PROFIT/LOSS SECTION.

NUMBER OF EMPLOYEES AT RITA LOCATION: \_\_\_\_\_ MONTHLY GROSS PAYROLL AT RITA LOCATION: \_\_\_\_\_

WILL YOU BE WITHHOLDING RESIDENCE TAX ONLY?  YES  NO

**SEND WITHHOLDING TAX FORMS TO**

BUSINESS NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

CARE OF: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

**IF YOU ARE A NON-PROFIT ORGANIZATION STOP HERE AND SIGN AT BOTTOM**

**PROFIT/LOSS INFORMATION**

ENDING DAY OF FISCAL YEAR IF OTHER THAN CALENDAR YEAR \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
MONTH DAY YEAR

**SEND NET PROFIT TAX RETURN TO**

BUSINESS NAME: \_\_\_\_\_ PHONE: (\_\_\_\_\_) \_\_\_\_\_

CARE OF: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

THE INFORMATION HEREBY SUBMITTED IS TRUE AND CORRECT.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PRINT NAME: \_\_\_\_\_ TITLE: \_\_\_\_\_ PHONE: \_\_\_\_\_

# CONTRACTOR INFORMATION

MUNICIPALITY: \_\_\_\_\_  
 ADDRESS OF CONSTRUCTION SITE: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

BUILDING PERMIT #: \_\_\_\_\_  
 TOTAL CONTRACT AMOUNT: \$ \_\_\_\_\_

As the contractor, will your company be withholding local income tax from all employees on the job?  YES  NO

COMPANY/ADDRESS - CITY, STATE AND ZIP	OFFICER/OWNER NAME PHONE NUMBER	SOCIAL SECURITY OR FEDERAL I.D. NUMBER	ESTIMATED START DATE	NUMBER OF EMPLOYEES	ESTIMATED WAGES PER MONTH	TRADE
BCS 02021-REG-OE						
BCS 02021-REG-OE						
BCS 02021-REG-OE						
BCS 02021-REG-OE						
BCS 02021-REG-OE						
BCS 02021-REG-OE						
BCS 02021-REG-OE						

If necessary attach a separate sheet

The information requested on this form is essential to the establishment of your account and will be held in strict confidence. Please complete and sign this Registration Form and return within 15 days. Prompt completion of this form now can save you the expenditure of additional time and effort in the future. If you have any questions please contact the Business Registration Department at one of the numbers below. Thank you for your cooperation.

SEND RESPONSE TO:

REGIONAL INCOME TAX AGENCY  
 ATTN: BUSINESS REGISTRATION  
 P.O. BOX 477900  
 BROADVIEW HEIGHTS, OH 44147-7900

CLEVELAND TOLL FREE: (800) 860-RITA (7482)  
 COLUMBUS TOLL FREE: (866) 721-RITA (7482)  
 YOUNGSTOWN TOLL FREE: (866) 750-RITA (7482)

TDD: (440) 526-5332  
 FAX: (440) 526-3136