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.: __________________________