

License Application: Taxicab Vehicle – New License

- ☐ **Taxicab Vehicle:** A motor vehicle engaged in the business of transporting passengers for hire, with a maximum seating capacity of seven (7) persons, not operating on a fixed route or schedule. This license is not required for limousines.
- ☐ **Taxicab Wheelchair Accessible Vehicle:** A minivan or similar vehicle specially adapted for individuals who use wheelchairs and prioritizes requests for service from individuals who use wheelchairs.

A vehicle inspection must be completed before the license is approved. A copy of the [Inspection Report](#) must remain in the vehicle. Anyone who drives a Minneapolis licensed taxicab must have a [Minneapolis Taxicab Driver's License](#).

If you have any questions, call 612-673-2080 or send an email to businesslicenses@minneapolismn.gov.

1. Application Requirements

1. Complete the application and include all the requirements listed below. Incomplete applications may be returned. You may send your application by email (businesslicenses@minneapolismn.gov), US mail, or drop it off at our office.
2. There is a [fee](#), plus a \$20 Wheelchair Surcharge, for this application. You can pay by
 - ☐ **Cash:** Drop off your application at our office.
 - ☐ **Check:** Mail or drop off your application at our office.
 - ☐ **Credit Card:** Mail, drop off or email your application to businesslicenses@minneapolismn.gov. **Do not add your credit card information on this application.** We will call you to securely charge your credit card.
 - ☐ **N/A** - \$20 Wheelchair Surcharge. My vehicle is wheelchair accessible and my paperwork is attached.
3. ☐ **Photo ID:** Attach a copy of the driver's license/government issued picture identification card for each owner.
4. ☐ **Attach a [Certificate of Liability Insurance](#).** (Sample Form #1)
 - a. This must be furnished by your insurance agent.
 - b. You are required to have a policy for the negligent operation, use or defective condition of any taxicab with the following coverages:
 - ☐ \$100,000 per occurrence and not \$300,000 aggregate for personal injury or death and
 - ☐ \$100,000 for per occurrence for property damage.
 - c. Policy may not contain any liability limitation for the vehicle, driver or occupants related to intoxication or illegal transportation of liquor.
5. ☐ **Title of Vehicle:** Attach a copy of the vehicle title, lease agreement, or receipt of title transfer.
6. ☐ **[Taxi Vehicle Inspection Report](#)** (Form #2): A list of [Authorized Garages](#) is on our website.
 - ☐ **Wheelchair Accessible Taxicabs must attach a [State of Minnesota Vehicle Inspection Form](#),** completed in the last 12 months, certifying this vehicle is in compliance with MN Statute [299A.14](#).
7. ☐ **Ownership Information**
 - ☐ Sole Proprietorship
 - ☐ Partnership or Shareholder: Attach a copy of the signed and executed partnership agreement.
 - ☐ Corporation: Attach a copy of the Certificate of Incorporation, Articles of Incorporation, by-laws and Certificate of Authority if a foreign corporation.

8. ☐ **Background Report** - Attach reports from each state you lived in for the past five years. [Minnesota](#) (651-793-2400); [Wisconsin](#) (608- 266-7314) or use this list of [state telephone numbers](#). You may not have Any felony convictions in the last five years, nor any nontraffic gross misdemeanor or misdemeanor convictions in the last three years involving the use of force, possession or sale of a controlled substance, prostitution, or indecent conduct. ***This report must be dated within 30 days of receipt of this application.***
9. ☐ **Service Company Authorization** (Form #3) - Attach a signed Service Company Authorization verifying your employment.

2. Background Information

Applicant/Owner's Name (Last, First, Middle)	<input type="checkbox"/> Taxi Vehicle <input type="checkbox"/> Wheelchair Accessible Taxi	Cell Phone Number
Social Security Number or ITIN – Required	Email Address – Required	MN Sales Tax ID #

Five (5) Years of Residential History

Home Street Address	City	State	Zip	Years	Months

3. Owner's Business Information

Legal/Corporate Name of Company	Trade Name/DBA
---------------------------------	----------------

Business Address	Service Company
------------------	-----------------

List all Owners and Partners (Attach additional sheets if necessary.)

Full Name: Last, First, Middle	Telephone	Date of Birth	Title/% of Ownership
Home Address	City	State	Zip Code
Full Name: Last, First, Middle	Telephone	Date of Birth	Title/% of Ownership
Home Address	City	State	Zip Code
Full Name: Last, First, Middle	Telephone	Date of Birth	Title/% of Ownership
Home Address	City	State	Zip Code

Have you ever had a business license denied or revoked by Minneapolis or another government entity? ☐ YES ☐ NO
 If Yes, Indicate the Date of Denial/Revocation, Government Agency, and Reason for Denial or Revocation.

List any licenses you currently have or previously held in Minneapolis (Business or Individual):

4. Vehicle				
Year	Make	Model	Cab Number	Seating Capacity
VIN Number		License Plate Number		State

5. Workers Compensation		
Workers' Compensation Company	Policy Number	Dates of Coverage

Or:

I certify that I am not required to carry workers' compensation insurance because: ☐ I am self-insured.
☐ I am the sole proprietor and I have no employees. ☐ I have no employees who are covered by workers' compensation law. Only employees who are specifically exempted by statute are not covered by the workers' compensation law. These include spouse, parents, and children regardless of age. All other workers whose work is controllable by the employer must be covered.

6. Data Privacy
The City of Minneapolis uses the information on this application to determine qualifications for a license. You are not legally required to provide this information. If you refuse, we cannot approve your application. MN Statute 270C.72 requires your Minnesota Tax ID Number, Social Security Number, or Individual Tax ID Number. These may be given to the Minnesota Commissioner of Revenue if requested. After we approve your license, all information except your Social Security Number is public (MN Statutes, Chapter 13).

7. Verification
<p>The data you furnish on this application will be used by the City of Minneapolis to assess your qualifications for licensure. Disclosure of this information is voluntary. You are not legally required to provide this data; however, if you fail to do so, the City of Minneapolis may be unable to process this application. Disclosure of your Minnesota Tax ID Number, Social Security Number, or Individual Tax ID Number is required by Minnesota Statutes 270C.72, and your Social Security number may be requested by and released to the Minnesota Commissioner of Revenue. After issuance of a license, all information contained in this application, except your Social Security Number, will be public information pursuant to Minnesota Statutes, Chapter 13.</p> <p style="text-align: center;">A signature is required.</p> <p><input type="checkbox"/> I have read and agree to the Data Privacy Advisory.</p> <p><input type="checkbox"/> I have read and agree to the Terms and Conditions for electronic signatures, records and payment.</p> <p>I, (print name) _____, certify or declare under penalty of perjury under the laws of the State of Minnesota that the information on this application, checklist, and attached documents is true and correct. All information given is subject to verification by the State of Minnesota. I understand that false information may result in the denial, suspension or revocation of my business license.</p> <p>By typing your name, you are electronically signing this application.</p> <p>Signature of Owner _____ Date _____</p>

Additional Information

1. Your License Application

- a. Incomplete applications may be returned. All applications must be signed by the owner.
- b. No license will be issued for a period longer than one year. Licenses are not transferable.
- c. Make a duplicate copy of this packet for your personal records before submitting.

2. Information in Other Languages: Para asistencia 612-673-2700 - Rau kev pab 612-673-2800 - Hadii aad Caawimaad u baahantahay 612-673-3500.

3. Reasonable Accommodations or Alternative Formats: Please call 612-673-2080 or an email to businesslicenses@minneapolismn.gov. Individuals who are deaf or hard of hearing can use a relay service to call 311 at 612-673-3000.

CERTIFICATE OF LIABILITY INSURANCE

**Certificate cannot be pending,
binder or TBA.**

The Legal/Corporate name must match exactly (word for word) to the Approved License Name (including Inc. or LLC), Trade Name (DBA), address of premises, and vehicle title.

**Notice of Cancellation required
by MN Statute 60a.39. Add
this statement to certificate or
attach policy provisions.**

The city must be named on the policy as an additional insured.

Original signature or stamp of agent.

<p>THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.</p>																																																																																																																																																												
<p>IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).</p>																																																																																																																																																												
PRODUCER Agency Address City, State, Zip					CONTACT NAME: _____ PHONE (A/C No, Ext): _____ FAX (A/C No): _____ E-MAIL ADDRESS: _____																																																																																																																																																							
INSURED					INSURER(S) AFFORDING COVERAGE NAIC #																																																																																																																																																							
					INSURER A : _____																																																																																																																																																							
					INSURER B : _____																																																																																																																																																							
					INSURER C : _____																																																																																																																																																							
					INSURER D : _____																																																																																																																																																							
					INSURER E : _____																																																																																																																																																							
					INSURER F : _____																																																																																																																																																							
<div style="display: flex; justify-content: space-between;"> COVERAGES CERTIFICATE NUMBER: _____ REVISION NUMBER: _____ </div>																																																																																																																																																												
<p>THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.</p>																																																																																																																																																												
<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th style="width:5%;">INSR LTR</th> <th style="width:25%;">TYPE OF INSURANCE</th> <th style="width:10%;">ADDL SUBR INSR WVD</th> <th style="width:15%;">POLICY NUMBER</th> <th style="width:10%;">POLIC (MM/DD/Y)</th> <th style="width:10%;">POLICY (MM/DD/Y)</th> <th style="width:35%;">LIMITS</th> </tr> </thead> <tbody> <!-- General Liability --> <tr> <td></td> <td>GENERAL LIABILITY</td> <td></td> <td></td> <td></td> <td></td> <td>EACH OCCURRENCE \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>COMMERCIAL GENERAL LIABILITY</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>TO RENTED VEHICLES (Ea occurrence) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>CLAIMS-MADE <input type="checkbox"/> OCCUR</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>MED EXP (Any one person) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>PERSONAL & ADV INJURY \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>GENERAL AGGREGATE \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>PRODUCTS - COMP/OP AGG \$</td> </tr> <tr> <td></td> <td>GEN'L AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <!-- Automobile Liability --> <tr> <td></td> <td>AUTOMOBILE LIABILITY</td> <td></td> <td></td> <td></td> <td></td> <td>COMBINED SINGLE LIMIT (Ea accident) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>ANY AUTO</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>BODILY INJURY (Per person) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>ALL OWNED AUTOS</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>BODILY INJURY (Per accident) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>SCHEDULED AUTOS</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>PROPERTY DAMAGE (Per accident) \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>HIRED AUTOS</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <!-- Umbrella Liability --> <tr> <td></td> <td>UMBRELLA LIAB</td> <td></td> <td></td> <td></td> <td></td> <td>EACH OCCURRENCE \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>EXCESS LIAB</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>AGGREGATE \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>CLAIMS-MADE</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td>\$</td> </tr> <tr> <td><input type="checkbox"/></td> <td>DED <input type="checkbox"/> RETENTION \$</td> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> </tr> <!-- Workers Compensation --> <tr> <td></td> <td>WORKERS COMPENSATION AND EMPLOYERS' LIABILITY</td> <td></td> <td></td> <td></td> <td></td> <td>WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/></td> <td>ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below</td> <td><input type="checkbox"/></td> <td>N/A</td> <td></td> <td></td> <td>E.L. EACH ACCIDENT \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>E.L. DISEASE - EA EMPLOYEE \$</td> </tr> <tr> <td><input type="checkbox"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>E.L. DISEASE - POLICY LIMIT \$</td> </tr> </tbody> </table>										INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLIC (MM/DD/Y)	POLICY (MM/DD/Y)	LIMITS		GENERAL LIABILITY					EACH OCCURRENCE \$	<input type="checkbox"/>	COMMERCIAL GENERAL LIABILITY	<input type="checkbox"/>				TO RENTED VEHICLES (Ea occurrence) \$	<input type="checkbox"/>	CLAIMS-MADE <input type="checkbox"/> OCCUR	<input type="checkbox"/>				MED EXP (Any one person) \$	<input type="checkbox"/>						PERSONAL & ADV INJURY \$	<input type="checkbox"/>						GENERAL AGGREGATE \$	<input type="checkbox"/>						PRODUCTS - COMP/OP AGG \$		GEN'L AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/>					\$		AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$	<input type="checkbox"/>	ANY AUTO	<input type="checkbox"/>				BODILY INJURY (Per person) \$	<input type="checkbox"/>	ALL OWNED AUTOS	<input type="checkbox"/>				BODILY INJURY (Per accident) \$	<input type="checkbox"/>	SCHEDULED AUTOS	<input type="checkbox"/>				PROPERTY DAMAGE (Per accident) \$	<input type="checkbox"/>	HIRED AUTOS	<input type="checkbox"/>				\$		UMBRELLA LIAB					EACH OCCURRENCE \$	<input type="checkbox"/>	EXCESS LIAB	<input type="checkbox"/>				AGGREGATE \$	<input type="checkbox"/>	CLAIMS-MADE	<input type="checkbox"/>				\$	<input type="checkbox"/>	DED <input type="checkbox"/> RETENTION \$	<input type="checkbox"/>						WORKERS COMPENSATION AND EMPLOYERS' LIABILITY					WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/>	<input type="checkbox"/>	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/>	N/A			E.L. EACH ACCIDENT \$	<input type="checkbox"/>						E.L. DISEASE - EA EMPLOYEE \$	<input type="checkbox"/>						E.L. DISEASE - POLICY LIMIT \$
INSR LTR	TYPE OF INSURANCE	ADDL SUBR INSR WVD	POLICY NUMBER	POLIC (MM/DD/Y)	POLICY (MM/DD/Y)	LIMITS																																																																																																																																																						
	GENERAL LIABILITY					EACH OCCURRENCE \$																																																																																																																																																						
<input type="checkbox"/>	COMMERCIAL GENERAL LIABILITY	<input type="checkbox"/>				TO RENTED VEHICLES (Ea occurrence) \$																																																																																																																																																						
<input type="checkbox"/>	CLAIMS-MADE <input type="checkbox"/> OCCUR	<input type="checkbox"/>				MED EXP (Any one person) \$																																																																																																																																																						
<input type="checkbox"/>						PERSONAL & ADV INJURY \$																																																																																																																																																						
<input type="checkbox"/>						GENERAL AGGREGATE \$																																																																																																																																																						
<input type="checkbox"/>						PRODUCTS - COMP/OP AGG \$																																																																																																																																																						
	GEN'L AGGREGATE LIMIT APPLIES PER: POLICY <input type="checkbox"/> PRO-JECT <input type="checkbox"/> LOC <input type="checkbox"/>					\$																																																																																																																																																						
	AUTOMOBILE LIABILITY					COMBINED SINGLE LIMIT (Ea accident) \$																																																																																																																																																						
<input type="checkbox"/>	ANY AUTO	<input type="checkbox"/>				BODILY INJURY (Per person) \$																																																																																																																																																						
<input type="checkbox"/>	ALL OWNED AUTOS	<input type="checkbox"/>				BODILY INJURY (Per accident) \$																																																																																																																																																						
<input type="checkbox"/>	SCHEDULED AUTOS	<input type="checkbox"/>				PROPERTY DAMAGE (Per accident) \$																																																																																																																																																						
<input type="checkbox"/>	HIRED AUTOS	<input type="checkbox"/>				\$																																																																																																																																																						
	UMBRELLA LIAB					EACH OCCURRENCE \$																																																																																																																																																						
<input type="checkbox"/>	EXCESS LIAB	<input type="checkbox"/>				AGGREGATE \$																																																																																																																																																						
<input type="checkbox"/>	CLAIMS-MADE	<input type="checkbox"/>				\$																																																																																																																																																						
<input type="checkbox"/>	DED <input type="checkbox"/> RETENTION \$	<input type="checkbox"/>																																																																																																																																																										
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY					WC STATU-TORY LIMITS <input type="checkbox"/> OTH-ER <input type="checkbox"/>																																																																																																																																																						
<input type="checkbox"/>	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICE/MEMBER EXCLUDED? (Mandatory In NH) If yes, describe under DESCRIPTION OF OPERATIONS below	<input type="checkbox"/>	N/A			E.L. EACH ACCIDENT \$																																																																																																																																																						
<input type="checkbox"/>						E.L. DISEASE - EA EMPLOYEE \$																																																																																																																																																						
<input type="checkbox"/>						E.L. DISEASE - POLICY LIMIT \$																																																																																																																																																						
DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (Attach ACORD 101, Additional Remarks Schedule, if more space is required)																																																																																																																																																												
CERTIFICATE HOLDER					CANCELLATION																																																																																																																																																							
ADDITIONAL INSURED: City of Minneapolis – Licenses and Consumer Services 505 Fourth Ave S., Room 220 Minneapolis, MN 55415					SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.																																																																																																																																																							
					AUTHORIZED REPRESENTATIVE																																																																																																																																																							

Applications will be returned if requirements are not complete.

Taxi/TNC Company:
<input type="checkbox"/> TNC <input type="checkbox"/> Taxi <input type="checkbox"/> Wheelchair Accessible
MPLS LICENSE #
Type of Inspection: <input type="checkbox"/> INITIAL <input type="checkbox"/> ANNUAL <input type="checkbox"/> SPECIAL <input type="checkbox"/> CAR TO CAR

City of Minneapolis
 Licenses and Consumer Services
 350 South 5th Street – Room 1
 Minneapolis, MN 55415-1316
 Phone: 612-673-2080 or 311
 Fax: 612-673-3399
 TTY: 612-673-2157

www.ci.minneapolis.mn.us/business-licensing

Facility Name:
Address:
Telephone:

Taxi/TNC Vehicle Inspection Report

Vehicle Owner Name			Telephone	Cab #
Vehicle Year	Make	VIN (last 6 digits)	License Plate	Odometer

F = FAIL/ OUT OF SERVICE P = PASS

1. BELTS, HOSES, LUBRICANTS		F	P	7. STEERING		F	P	11. BODY		F	P
<input type="checkbox"/> P/S	<input type="checkbox"/> ALT			STEERING LINKAGES /COMPONENTS				PAINT COLOR, DENTS, DINGS, RUST			
<input type="checkbox"/> AIR PUMP	<input type="checkbox"/> A/C			BALL JOINTS				WINDSHIELD			
<input type="checkbox"/> CRACK	<input type="checkbox"/> HEATER			PINION SEALS				DOORS			
<input type="checkbox"/> SOFT	<input type="checkbox"/> RAD			TIRE WEAR <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR				DOOR HANDLES <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR			
PULLEYS & WATER PUMP				TIRE WEAR/RIM CONDITION				DOOR WINDOW <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR			
RADIATOR & PRESSURE CAP				WHEEL ALIGNMENT- TEST/VISUAL				FENDERS – FRONT			
COOLANT: <input type="checkbox"/> LEVEL <input type="checkbox"/> COND				PS PUMP AND LEAKS				QUARTER PANELS - REAR			
TRANS FLUID <input type="checkbox"/> LEVEL <input type="checkbox"/> COND				8. INSTRUMENTS		F	P	MIRRORS <input type="checkbox"/> LF <input type="checkbox"/> INTERIOR <input type="checkbox"/> RF			
ENGINE OIL: <input type="checkbox"/> LEVEL <input type="checkbox"/> COND				OIL PRESSURE				BUMPER COVERS			
PWR STR FLUID <input type="checkbox"/> LEVEL				ENGINE TEMP				DECAL/COMPANY MARKING			
BATTERY POSTS & CABLES				CHARGING SYSTEM				REAR WINDOW SHELF			
2. POLLUTION CTRL/FUEL SYS		F	P	SPEEDOMETER				GLASS			
FUEL LEADS (VISUAL)				ODOMETER				GENERAL BODY CONDITION			
GAS TANK				HEATER/DEFROSTER				12. GENERAL		F	P
GAS GAUGE				AIR CONDITIONING				HORN			
IDLE NORMAL:				SRS AIRBAGS				AIR CONDITIONER			
3. ENGINE/POWER ANALYSIS		F	P	METER – OPERATIONAL				FAN SPEED			
TEST	ENGINE PERFORMANCE			LOCATION				WS WIPERS/WASHER			
DRIVE	ENGINE NOISES			SEAL				HEADLIGHTS			
	NORMAL ACCELERATION			<input type="checkbox"/> N/A				FOCUS/CANDLE POWER			
ACCELERATION CABLE				CHECK ENGINE LIGHT				HI LOW PARKING			
ENGINE MOUNTS				OPERATIONAL				RIGHT TURN LIGHTS			
OIL LEAKS				CODES INDICATED				LEFT TURN LIGHTS			
4. TRANSMISSION		F	P	9. BRAKING SYSTEM		F	P	BRAKE LIGHTS			
TEST	NORMAL TRAN OPERATION			FLUID LEVEL				13. TRUNK		F	P
DRIVE	SPEEDOMETER OPERATION			PEDAL RESERVE				SPARE TIRE <input type="checkbox"/> N/A			
	GEAR SHIFT INDICATOR			BRAKE HOSES & LINES				TRUNK UPHOLSTERY CONDITION			
5. DRIVE TRAIN		F	P	MASTER CYLINDER/ABS				LATCH OPENS CLOSSES			
TEST	DRIVE LINE:			PARKING BRAKE				FUEL LEAKS/SMELLS			
DRIVE	<input type="checkbox"/> NOISE			REMAINING LINING/PAD				14. INTERIOR		F	P
	<input type="checkbox"/> VIBRATION			FRONT REAR				DRIVER/PASSENGER INTERIOR			
UNIVERSAL & CV JOINTS				WHEEL CYLINDERS/CALIPERS				UNCLEAN/DIRTY/SOIL/ODORS			
REAR AXLE SEALS				DRUM/DISC CONDITION				FRONT SEAT # REAR SEAT #			
DIFFERENTIAL & FLUID LEVEL				10. SUSPENSION/FRAME		F	P	CONDITION:			
6. EXHAUST SYSTEM		F	P	FRAME/ENERGY ABSORB BUMPER				DASHBOARD			
CATALYTIC CONVERTER				FRAME/CROSS BARS				HEADLINER			
EXHAUST PIPE/TAIL PIPE				STABILIZER BAR & LINKS				SEATBELTS (FRONT/REAR)			
MUFFLER				STRUT/SOCKS <input type="checkbox"/> LF <input type="checkbox"/> RF <input type="checkbox"/> LR <input type="checkbox"/> RR				FLOORS			
HANGER/CLAMPS				SPRINGS/BRUSHINGS				BRAILLE CARD, RATE CARD <input type="checkbox"/> N/A			
								SECURITY DEVICE <input type="checkbox"/> N/A			
								<input type="checkbox"/> GPS <input type="checkbox"/> CAMERA <input type="checkbox"/> SHIELD			

☐ N/A – The requirement does not apply to TNC vehicle.

Comments:

Date of Inspection	Inspection Results <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Technician Name (print)	Technician Signature	Employee #
Date of Inspection	Reinspection Results <input type="checkbox"/> Pass <input type="checkbox"/> Fail	Technician Name (print)	Technician Signature	Employee #

Taxi Service Company License Authorization Form

Chapter 341.960 of the Minneapolis Code of Ordinances states Taxi Service Companies are responsible for the behavior of taxi drivers and operation of taxi vehicles. Your signed authorization verifies employment/operation with your company. Please complete the following information and return it to the driver/vehicle owner as part of their application form.

Name of Service Company: _____
Name of Service Company Representative: _____

<input type="checkbox"/> Driver, New License <input type="checkbox"/> Driver, Duplicate/Replacement License	<input type="checkbox"/> Taxi Vehicle, New License <input type="checkbox"/> Taxi Vehicle, Person to Person Transfer
Name of Driver/Vehicle Owner: _____	
<input type="checkbox"/> I verify that the statements made in his/her application are true and that the provisions of Section 341.960 of the Minneapolis Code of Ordinances have been completely complied with to the best of my knowledge and belief.	
Service Company Representative Signature: _____ Date: _____	

<input type="checkbox"/> Driver, Company Transfer License	<input type="checkbox"/> Vehicle, Company Transfer
Old Service Company	
Name of Service Company: _____	
Name of Service Company Representative: _____	
Service Company Representative Signature: _____ Date: _____	
New Service Company	
<input type="checkbox"/> I verify that the statements made in his/her application are true and that the provisions of Section 341.960 of the Minneapolis Code of Ordinances have been completely complied with to the best of my knowledge and belief.	
New Service Company Representative Signature: _____ Date: _____	

<input type="checkbox"/> Wheelchair Accessible Vehicle
<input type="checkbox"/> I verify that the statements made in this application are true and that the provisions of Section 341.960 of the Minneapolis Code of Ordinances have been completely complied with to the best of my knowledge and belief. I further verify that I have personally reviewed the attached State of Minnesota vehicle inspection form and acknowledge that it complies with the requirements of MN Statute 299A.14.
Service Company Representative Signature: _____ Date: _____