STATE OF CALIFORNIA

WORKER'S COMPENSATION INSURANCE VERIFICATION

PR-PML-120 (REV. 12/04)

DEPARTMENT OF PESTICIDE REGULATION
PEST MANAGEMENT AND LICENSING BRANCH
LICENSING AND CERTIFICATION PROGRAM
1001 I STREET
SACRAMENTO, CALIFORNIA 95814-2828
(916) 445-4038
FAX - (916) 445-4033
Web site: http://www.cdpr.ca.gov/

A. Declaration. Please print or type.

I, _____ , the undersigned, verify under penalty of perjury, under laws of the State of
Name

California, that the information provided below, is true and correct. The business mentioned herein is covered by worker's compensation insurance:_____
Name of Business

License number:_____ . Telephone number: (___)_____ .

B. Worker's Compensation Insurance Information. Please print or type.

Worker's Compensation Insurance Carrier Name	Policy Number	Expiration Date

Telephone Number ( )	Email Address

C. Sign and Mail. Sign, date and complete the address information listed below. Mail to: Pest Management and Licensing, Licensing and Certification Program, Department of Pesticide Regulation, P.O. Box 4015, Sacramento, California 95812-4015.

Signature	Title	Date

Address	City, State	Zip Code