INDIGENOUS HEALTHCARE PRACTITIONERS ORGANIZATION

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: ☐

- pay a tribal donation fee of five percent (5%) on gross receipts for all goods and services;
- provide the Tribal Donation Form with my tribal donation payments; and
- make tribal donation payments on a monthly, quarterly, semi-annual or annual basis.

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: (1) the IHCPO Business License creates a tribal enterprise that operates as a non-profit entity with d/b/a under the Turtle Healing Band Clinic; (2) payment must accompany my submission before my application can be processed; (3) in the event my application is not approved only 50% (fifty percent) of my application fee will be refunded; and (4) failure to pay tribal donations may require a financial audit before my tribal business can be renewed.

_____
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