

Sole Proprietor Statement

Business Name (DBA) _____

Business Address _____

The purpose of this form is to document that the above individual as a sole proprietor without employees and not subject to the Workers' Disability Compensation Act.

- I am a sole proprietorship. As such, **I am not** a corporation, partnership, or limited liability company.
- As a sole proprietorship, **I do not** hire any employees, casual labor or subcontractors with employees.
- I pay my own business operational expenses.
- I acknowledge that as a sole proprietorship without employees, I am by law not covered by or subject to the Workers' Disability Compensation Act.
- If I am an owner/operator, I am the owner and sole operator of the truck used.
- If any of the above should change, I will notify you prior to performing the next job.
- If requested, I agree to provide documentation to verify my status as a sole proprietorship without employees.

My signature on this document confirms that the above statements are true.

Signature of sole proprietor

Date

This signed form may be returned by fax.