Video Franchise

VIDEO FRANCHISE NAME:

REGULATORY CONTACT:
NAME:
ADDRESS:
CITY ST ZIP

AUTHORIZED COMPANY REP:
NAME:
ADDRESS:
CITY ST ZIP

1. Principal office address:
____________________________________________
____________________________________________

Make check payable to:
Department of Financial Institutions
Mail to:  P O Box 7846
Madison WI  53707

2. Number of Subscribers:

☐ This entity has fewer than 10,000 subscribers (Fee is $2,000.00)
☐ This Entity has 10,000 or more subscribers    (Fee is $5,000.00)

For the Video Franchise: ________________________________
(Name of Video Franchise)

____________________________________________
Signature title:________________________

Signature: ________________________________

This Report (Form 3000A) is a required form under s. 66.0420, Wis. Stats. Upon filing, the data in the form shall become public record and may be used for purposes other than that for which it was originally collected.

DFI/SICFA/3000A(R11/12)