330 Passaic Street
Passaic, NJ 07055
973-365-5632/973-365-5653
zoning@cityofpassaicnj.gov

PERMIT NUMBER

#_____

SHORT TERM RENTAL CERTIFICATE REGISTRATION

Date: _____

Name of Owner/ Entity:_____

Address:_____

Phone: _____Email: _____

Responsible Party/ Agent:_____

Address:_____

24 hour/ 7 day Phone Number: _____Email: _____

Proposed Short Term Rental Address:_____

Zone:_____ Block:_____ Lot:_____

Type of Dwelling: ☐ Single-Family ☐ Townhouse ☐ Condo ☐ Other:_____

Number of Bedrooms: _____ Number of on-site parking spaces available:_____

Brief Description of the Proposed Short Term Rental Space: _____

_____

_____

APPLICATION WILL NOT BE ACCEPTED OR REVIEWED UNLESS IT IS ACCOMPANIED BY ALL REQUIRED CHECKLIST ITEMS

I hereby certify that all statements, information and documents submitted in support of this application are true, accurate, and complete to the best of my knowledge and belief. I understand that any false statements, misrepresentations, or omissions may result in the denial of this application and may be subject to penalties as provided by law.

Signature of Applicant:_____ Date: _____

OFFICE USE ONLY

Permit: ISSUED_____ DENIED_____

Notes: _____

Non- Refundable Fee: $250 Check #_____Date:_____Zoning Official_____