**Incubation Program Application – St. Croix Valley Business Innovation Center**

*This application is used in part to determine the eligibility for acceptance into the Incubation Program at the St. Croix Valley Business Innovation Center. Additional information may be required as part of the application process. Proprietary information will be treated as confidential.*

1. **COMPANY BACKGROUND**

|  |  |  |
| --- | --- | --- |
| Company Name |  | |
| Current Company Address |  | |
| Company Phone |  | |
| Website |  | |
| Date of company formation |  | |
| What is the Legal form of your Business? | LLC  C-Corporation  General Partnership | LLP  S-Corporation  Sole Proprietorship |

1. **CONTACT INFORMATION**

|  |  |
| --- | --- |
| Applicant First Name |  |
| Applicant Last Name |  |
| Title |  |
| Address [Street] |  |
| City, State, and Zip |  |
| Phone |  |
| E-Mail |  |
| Ownership % (if applicable) |  |

1. **Attach your business plaN and past two years of financials (if available)**
   1. Here is a business plan template (attach pdf)
   2. If you don’t have two years of financial statements, please explain.

1. **INTELLECTUAL PROPERTY**

Do you hold proprietary rights (patents/ licenses) for any technologies you have or are developing?

Yes (List all Patent #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)  No  In progress  Not applicable

1. **KEY PERFORMANCE INDICATORS**

Clients will be required to set goals and report on Key Performance Indicators. Please indicate your current status and goals in the below categories:

Job Creation

Indicate how many full-time equivalent (FTE) employees you currently have (including owners). Also, estimate the number of new full-time equivalent (FTE) positions that will be added to your company over the next three years. (Indicate part-time positions as a decimal, ex: 1.50 FTE is one full-time employee and a 50% part-time employee):

|  |  |  |
| --- | --- | --- |
| Current | # Full-time Equivalent Employees |  |
| Year One | # Full-time Equivalent Employees Added |  |
| Year Two | # Full-time Equivalent Employees Added |  |
| Year Three | # Full-time Equivalent Employees Added |  |

Capital infusion (money received for your business)

Estimate the amount of money you expect to infuse in your business over the next three years from the following sources:

|  |  |  |  |
| --- | --- | --- | --- |
| **Source of Money** | **Year One Amount** | **Year Two Amount** | **Year Three Amount** |
| Friends and family |  |  |  |
| Personal investment |  |  |  |
| Loan from accredited lender |  |  |  |
| Equity investment |  |  |  |
| Profit reinvestment |  |  |  |
| Grants |  |  |  |
| Other |  |  |  |

1. **INCUBATOR SPACE**

|  |  |
| --- | --- |
| What type of space do you need? | Private Office  Open Workspace  Light Industrial  Other (describe): |
| Approximately how much space will you need (sq. ft.)? |  |
| When do you estimate you will need to take occupancy of the space? |  |
| Will your company require any specific interior or exterior security measures? | YES  NO  If yes, describe: |
| Please list any special facility requirements that your company will need (power, lighting, ventilation etc.) |  |
| Describe your company’s operations that you propose to locate in the Innovation Center. |  |
| The incubation program will last 2-3 years. Where do you plan to locate after graduating from the program? |  |
| If you will require any reasonable accommodations due to a disability, please describe them here. |  |

1. **MATERIALS AND EQUIPMENT**

If you will be conducting research or manufacturing operations that require the use of any flammable, volatile, toxic or other chemicals, please list them below. (You will be required to provide Material Safety Data Sheets for all chemicals if your company is accepted into the Incubator.). Additionally, indicate any specialized equipment, machinery or other materials that will be stored at the facility.

|  |  |
| --- | --- |
| Name of Material/Equipment |  |
| Name of Material/Equipment |  |
| Name of Material/Equipment |  |
| Name of Material/Equipment |  |
| Name of Material/Equipment |  |

**\*if additional items, please attach**

1. **BUSINESS DEVELOPMENT SERVICES**

As part of the incubation program, we will evaluate your business needs and provide services as needed. Please describe any assistance that may be requested from the Innovation Center.



1. **REFERENCES**

Please provide two professional references (non-family).

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Relationship** | **Email** | **Phone** |
|  |  |  |  |
|  |  |  |  |

1. **CERTIFICATION**

Indicate your willingness to:

Participate in quarterly business reviews  
No Yes

Work with an advisory board  
No Yes

Meet with a business coach, as needed  
No Yes

Participate in Incubator educational/networking activities  
No Yes

Why do you want to locate in the Incubator?



All of the statements made in this assessment are true, accurate, and complete to the best of my knowledge. I understand that any false statement or material omission may lead to the disqualification of this assessment, or eviction from the Incubator if admitted to the residency.  
  
Further, I understand this assessment will require additional supporting materials and may be reviewed by additional Incubator staff, and I release the information for examination by those individuals. All materials will be kept confidential and may be provided to members of the St. Croix Valley Business Incubator Management Committee and the River Falls Economic Development Corporations Board of Directors.

Finally, I authorize the Incubator and/or its staff or designated agents to contact references given, as well as to secure credit reports on the entity applying for residency.  
  
I Agree to the above terms & conditions:   