

RI Department of Health

Application and Instructions for:



Asbestos Consultation Services

**DO NOT DUPLICATE THIS FORM
PLEASE DO NOT REMOVE ANY FULL PAGES FROM THIS BOOKLET**

INSTRUCTIONS

- Please answer all questions. Do not leave blanks. Incomplete forms will not be accepted and your license/permit will not be issued. Please use a ball point pen. Information can be obtained on our website at <http://www.health.ri.gov/environment/occupational/asbestos/licensing.php>
- If you are submitting this application by mail you must include the following:
 1. Completed, signed application
 2. \$200.00 (two-hundred-dollar) license fee for the initial area to be certified with this application and \$100.00 (one-hundred-dollar) license fee for each additional area being certified by this application. Payment should be submitted in the form of a Check or Money Order, made payable to **General Treasurer, State of RI**
 3. Electronic full-face color digital photograph
 4. Attachments as listed below

Mail to: Rhode Island Department of Health
 Healthy Environment Team – Asbestos Program
 Room 206 - 3 Capitol Hill
 Providence, RI 02908-5097

PLEASE NOTE: OUR OFFICE IS NOW OPEN TO THE PUBLIC MONDAY, TUESDAY, THURSDAY AND FRIDAY FROM 10:00 am TO 12:00 pm AND 1:00 pm TO 3:00 pm. **THERE WILL BE NO LICENSING ON WEDNESDAYS.**

DOORS WILL BE CLOSED AT ALL OTHER TIMES. PLEASE COME TO ROOM 206 FOR LICENSES ONLY DURING THESE HOURS.

PLEASE DO NOT LEAVE ANY DOCUMENTS WITH OTHER OFFICES.

If you have any questions concerning this application, call the Department of Health, **Asbestos Program** at (401) 222-7750.

Asbestos Consultation Services Requested: (Check all that apply)	<input type="checkbox"/> Asbestos Inspection Services [D.4.2 (b) (4)] <input type="checkbox"/> Asbestos Project Designer Services [D.4.2 (b) (5)] <input type="checkbox"/> Asbestos Management Planner Services [D.4.2 (b) (6)]
Documentation of Required Training:	Attach original or certified copy of certificate(s) indicating successful completion of all required training for each consultation service requested. Any training courses taken ONE (1) year prior to application must be supplemented by an Agency approved Annual Review course.
Fees:	_____Initial Area to be certified with this application @\$200.00 _____Additional area(s) to be certified with this application @\$100.00 Total Fee(s) Submitted: \$_____
Check or Money order payable to "General Treasurer, State of RI"	

State of Rhode Island and Providence Plantations Department of Health

<p>Name:</p> <p>This is the name that will be printed on your License and reported to those that inquire about your License.</p> <p>Do not use nicknames, etc.</p>	<p>Name: _____</p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center; width: 25%;">Prefix (Mr/Mrs/Dr.)</td> <td style="text-align: center; width: 30%;">First Name</td> <td style="text-align: center; width: 30%;">Last Name</td> <td style="text-align: center; width: 15%;">Suffix (Jr/III)</td> </tr> </table>	Prefix (Mr/Mrs/Dr.)	First Name	Last Name	Suffix (Jr/III)
Prefix (Mr/Mrs/Dr.)	First Name	Last Name	Suffix (Jr/III)		
<p>Date/Place of Birth:</p>	<p>Date of Birth: <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p> <p style="text-align: center; font-size: small;">Month Day Year</p> <p>Place of Birth: _____</p>				
<p>Gender:</p>	<p>Male <input type="checkbox"/> Female <input type="checkbox"/></p>				
<p>Residence Information:</p> <p>It is your responsibility to keep the Department apprised of all address and phone number changes.</p> <p>(Not published on the HEALTH web site).</p>	<p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, ZipCode _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>				
<p>Business/Employment Information:</p>	<p>Company Name _____</p> <p>Address Line 1 _____</p> <p>Address Line 2 _____</p> <p>Address Line 3 _____</p> <p>Address City, State, ZipCode _____</p> <p>Address Country _____</p> <p>Phone: _____</p> <p>Fax: _____</p> <p>Email Address: _____</p>				
<p>SSN:</p> <p>(Social Security Number)</p>	<p>Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or renewing any license, permit, or other authority to conduct a business or occupation within Rhode Island must have filed all required state tax returns and paid all taxes due the state or must have entered into a written installment agreement to pay delinquent state taxes that is satisfactory to the Tax Administrator.</p> <p>SSN: <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/></p>				

Certiification/Authorization in other Jursisdctions	<p>Indicate all other federal, state or local jurisdictions in which the applicant currently holds an asbestos consultant certificate and/or other authorization to perform asbestos consultation. Attach copies of all such certifications and/or authorizations.</p> <p>_____</p> <p>_____</p> <p style="text-align: right;"><input type="checkbox"/> Check if Not Applicable</p>
Enforcement Actions in Other Jurisdictions: If Yes, please provide details.	<p>1. Has any federal, state or local jurisdiction ever revoked or suspended an asbestos consultant certificate and/or authorization to perform asbestos consultation held by the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Does any federal, state or local jurisdiction have outstanding enforcement action(s) against the applicant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
Affidavit of Applicant Read, sign, and date this affidavit.	<p style="text-align: center;"><u>This Application Must be Signed by the Applicant</u></p> <p>I have read carefully the questions in the foregoing application and have answered them completely, without reservations of any kind, and I declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of this License in the State of Rhode Island.</p> <p>I understand that this is a continuing application and that I have an affirmative duty to inform the Rhode Island Department of Health of any change in the answers to these questions after this application and this Affidavit is signed.</p> <p>_____</p> <p>Signature</p> <p style="text-align: right;">_____</p> <p style="text-align: right;">Date of Signature (MM/DD/YY)</p>