Licensing Application for Clandestine Drug Laboratory Remediation Technician

WEST VIRGINIA BUREAU FOR PUBLIC HEALTH
Office of Environmental Health Services
Radiation, Toxics and Indoor Air Division
Clandestine Drug Laboratory Remediation Program
350 Capitol Street – Room 313
Charleston, WV 25301
Telephone (304) 558-2981 Fax (304) 558-0524 Website: www.wvdhhr.org/rtia

A. General Information (Follow all instructions below. Incomplete applications cannot be processed.)

1. **Type or print legibly in blue ink. Applications must have an original signature. Photocopies will not be accepted)**

2. **Attach required documentation (see below). All certificates must have valid expiration dates. Certificates from online courses will not be accepted.**
   - (a) A copy of WV Approved Initial or Refresher CDLR Technician Certification
   - (b) A copy of OSHA Hazardous Material Worker Certification
   - (c) A Copy of Driver License or State Issued ID

3. Attach check or money order payable to the **WV Bureau for Public Health.** Tax is not applicable. We cannot accept cash or credit cards.

4. Submit application, documentation, and check or money order to the above address. **Incomplete applications will be returned. If you wish to apply in person, please call for an appointment.**

5. Fee: Technician (check one): ☐ One year license - $50.00 ☐ Two year license - $100.00

Name of Applicant: _____ Date of Birth: _____

Social Security Number: _____ Driver License Number (State): _____

Address: _____ City: _____

State: _____ Zip Code: _____ Email: _____

Telephone: Home: ( ) _____ Work : ( ) _____

Employer: _____ Address: _____

City: _____ State: _____ Zip Code: _____

B. Applicant Attest: (Applications must have an original signature. Photocopies will not be accepted)

In accordance with Chapter 64, Article 92 of the Code of West Virginia, amended June 1, 2017, and the applicable promulgated rules, I hereby certify that all submitted information and documentation is true and correct and that I am familiar with all applicable licensing requirements.

Signature of Applicant: _____ Date_____

C. Health Department Use Only

App. No._____
Approved By _____Date_____
Denied By _____Date_____
Issue Date_____
Mailed To_____

Fee:

Paid By _____
Amount Paid_____
Check Number_____
Date of Check_____
Date Received _____