Licensing Application for Clandestine Drug Laboratory Remediation Contractor

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 25301-1798
Telephone (304) 558-2981 Fax (304) 558-0524

A. General Information (Follow the instructions below. Incomplete application cannot be processed.)

Read all instructions carefully. Type or print legibly in blue ink. Complete sections A and B

Attach a $300.00 check or money order payable to the **WV Bureau for Public Health.** Tax is not applicable. We can not accept cash or credit cards. (Application without a fee cannot be processed)

Name of Firm_____ Business Phone (_____)_____

Address_____ City_____

State_____ Zip Code _____ Fax Number (_____)_____

Registered with WV Tax Department: Yes_____No_____ Number _____

Registered with WV Department of Labor: Yes_____No_____ (In addition to the WV Clandestine Drug Laboratory Remediation Contractor License, a contractor must obtain a WV Contractor License from WV Dept. Of Labor before doing any Clandestine Drug Laboratory Remediation projects in WV.)

Clandestine Drug Laboratory Remediation Technician Name_____

Clandestine Drug Laboratory Remediation Technician License Number_____

Clandestine Drug Laboratory Remediation Technician Social Security Number_____

Do you employee technicians which hold license(s) from any other state? Yes_____ No_____
If yes, attach a list of the state(s) and license numbers.

Have you ever been the subject of any enforcement action relating to clandestine drug laboratory remediation taken by any federal or state agencies or courts? Yes_____ No_____
If yes, attach additional sheets to fully describe each action and its outcome.

B. Applicant Attest

In accordance with Chapter 64, Article 92 of the Code of West Virginia 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, Owner, Agent_____ Date_____

Title_____

C. Health Department Use Only **Fee:**

App. No._____
Approved By_____Date_____
Denied By_____Date_____
Issue Date_____
Mailed To_____

Paid By _____
Amount Paid_____
Check Number_____
Date of Check_____
Date_____