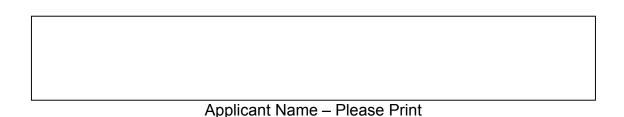


RI Department of Health

Application and Instructions for:

Radon Worker



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 application will be returned to you. Please use a ball point pen. Information can be obtained on our website at www.health.ri.gov
- Please mail your completed application, fee and the required documents to:

Rhode Island Department of Health Office of Healthy Homes and Environment Room 206 - 3 Capitol Hill Providence, RI 02908-5097

- 1. \$30.00 (thirty-dollar) license fee in the form of a Check or Money Order, made payable to **General**Treasurer, State of RI
- 2. Attachments as listed below

Required
Documentation

(A) Copy of certificate(s) indicating successful completion of all training required by the Rules and Regulations for Radon Control

Please make a photocopy of your entire completed application for your records before mailing to the office. The office is not responsible for providing you with a photocopy of your application.

You will be notified by mail when to appear to have your photograph taken and your ID badge printed.

Please allow the office fifteen (15) business days to process your application and notify you to appear to have your photograph taken.

Please call the Office of Healthy Homes and Environment at 401-222-5960 if you have any questions about the application process.

You may review the status of your application at the Department of Health's' license verification site: https://healthri.mylicense.com/Verification

State of Rhode Island and Providence Plantations **Department of Health** Name: This is the name that will be Name: printed on your License and Prefix First Name Last Name Suffix reported to those that (Mr/Mrs/Dr.) (Jr/III) inquire about your License. Do not use nicknames, etc. Date of Birth: Date of Birth: Male | Female Gender: Address Line 1 -Residence Information: Address Line 2 -It is your responsibility to keep the Department Address Line 3 apprised of all address and phone number changes. Address City, State, ZipCode _____ (Not published on the Address Country _____ HEALTH web site). Phone: ___ Fax: ----Email Address: ____ Company Name — **Business/Employment** Information: Address Line 1 — Please provide the Address Line 2 information of the licensed radon mitigation Address Line 3 _____ contractor(s) which you will be performing radon Address City, State, ZipCode ____ mitigation services. Address Country ___ Note: If you are providing services for more than one Phone: ---licensed mitigation contractor, attach this information on a separate sheet. Email Address: ___ Pursuant to Chapter 75 of Title 5 of the Rhode Island General Laws, as amended, any person applying for or SSN: 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.

(Social Security Number)

SSN:

Enforcement Actions in Other Jurisdictions: If Yes, please provide details.	Are there any outstanding or past enforcem with a radon project performed by the appli	nent actions by a federal_state or local jurisdictions in conduction cant? Yes No
Affidavit of Applicant	This Application Must be Signed by the Applicant	
Read, sign, and date this affidavit.	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. 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.	
	Signature	Date of Signature (MM/DD/YY)