

## **RI Department of Health**

## Application and Instructions for:

Radon Training Courses
Applicant Name – Please Print

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 <a href="https://www.health.ri.gov">www.health.ri.gov</a>
- 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. \$300.00 (three-hundred dollar) license fee for the first training course provided and an additional \$100.00 (one-hundred dollar) license fee for each additional course provided. Payment should be in the form of a Check or Money Order, made payable to **General Treasurer**, **State of RI**
- 2. Attachments as listed below

	CHECK ALL THAT APPLY
Radon Training Course(s) Submitted (check ALL	☐ 32 Hour Initial Radon Mitigation Specialist
applicable items):	☐ 16 Hour Initial Radon Inspector
** Fees: \$300.00 for first course and \$100.00 for each additional course provided.	Attach documentation to demonstrate compliance with the appropriate sections of the Rhode Island Rules and Regulations for Radon Control. Each attachment must clearly identify the specific paragraph(s) being addressed.

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.

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

	Department of fleatin
Facility Name:  Please provide the name of the facility (as known to the public) for which this certificate is being requested.  Facility Contact:  Please provide the facility. Phone, Fax and Email Information	Name:  Contact Name:  Phone Number:  Fax Number:  Email Address:
Facility Mailing Information:  Please provide the mailing information for all communication regarding this certificate, if different from Facility Location Information  (Not published on HEALTH website).	Address Line 1  Address Line 2  Address Line 3  Address City, State, ZipCode  Address Country  Phone:  Fax:  Email Address:
Facility Location Information  Please provide the location information for this facility  (Published on HEALTH website).  Ownership Type:  Please check ONE	Address Line 1  Address Line 2  Address City, State, ZipCode  Address Country  Phone:  Fax:  Email Address:  Limited Liability Company
Flease Clieck OINE	Governmental Entity Sole Proprietorship Limited Partnership Partner

Ownership Information:  Please provide the ownership	Name:
information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability	DBA:
Company or Governmental Entity.	
Enforcement Actions in Other Jurisdictions:	<ol> <li>Are there any outstanding or past enforcement actions by a federal, state or local jurisdictions in conjunction with a radon training course provided by the applicant and/or any principal in the applicant's organization?</li> </ol>
If yes, please provide details. Attach a separate sheet if needed.	YesNo
SSN/FEIN:	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
(Social Security Number/Federal Employer Identification Number)	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.
identification Number)	
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)