



RI Department of Health
3 Capitol Hill, Room 209
Providence, RI 02908-5097
www.health.ri.gov

RI Department of Health

Application and Instructions for:

Public Water System License:

- Community
- Non-Transient Non-Community
- Transient Non-Community

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

INSTRUCTIONS

- **The owner of the property on which the water system is located MUST apply for and hold the water system license. The property owner may or may not be the “Facility Contact Person”.**
- Please answer all questions. Do not leave blanks. Incomplete forms will be returned to you and your license/permit will not be issued. Please use a ballpoint pen.
- Attach your check or money order to the front of this booklet and mail to: Rhode Island Department of Health, Division of Drinking Water Quality, 3 Capitol Hill, Room 209, Providence, RI 02908-5097. Do not hand deliver this form to the Department of Health.
- Please send **one** check or money order.

Public Water System Fee Schedule

Transient Non-Community-\$200
Nontransient Non-Community-\$330
Community-\$1.50 per service connection
(\$330.00 minimum-\$32,500 maximum)

NOTE: Please do not enclose payment for water sampling and analytical services with this license application booklet. Payment for sampling and analytical services must be mailed separately.

- Make your check/money order payable to “General Treasurer, State of Rhode Island”. Do not send cash.
- If you have any questions concerning this application, call the Department of Health, **Office of Drinking Water Quality** at (401) 222-6867.
- Licensure application materials are public records as mandated by Rhode Island law and may be made available to the public, unless otherwise prohibited by State or Federal law.

Drinking Water Operator:

Name: _____

*Must be provided for
Community and Non-Transient
Non-Community Systems

License Number: _____

**State of Rhode Island and Providence Plantations
Department of Health**

Facility Name:

Please provide the name of the water system on the property for which this license will be issued.

Name: _____

Facility Contact Person:

Please provide the name, address and telephone number of a person we can contact concerning this facility.

Name: _____

Address Line 1 _____

Address Line 2 _____

Address City, State, Zip Code _____

Phone Number: ____ (____) _____

Facility Mailing Information:

Please provide the mailing information for all communication regarding this license.

(Not published on HEALTH website).

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip Code _____

Address Country _____

Phone: _____

Fax: _____

Email Address: _____

Facility Location Information:

Please provide the location information for this facility.

(Published on HEALTH website).

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip Code _____

Address Country _____

Phone: _____

Fax: _____

Email Address: _____

Property Ownership Type:

Corporation

Limited Liability Company

Please check ONE

Governmental Entity

Sole Proprietorship

Partnership

Limited Partnership

Partner

Ownership Information:

LIST ONE ONLY-DO NOT SUBMIT ATTACHMENTS

Please provide the property ownership information for the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Government Entity.

Name: _____

DBA: _____

Ownership Address Information:

Please provide the address and telephone number(s) of the Sole Proprietorship, Partnership, Limited Partnership, Corporation, Limited Liability Company or Government Entity that owns the property on which the water system is located..

Address Line 1 _____

Address Line 2 _____

Address Line 3 _____

Address City, State, Zip Code _____

Phone: _____

Fax: _____

Email Address: _____

FEIN Number:
of property owner

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.

(Federal Employer Identification Number)
Note: If you are a sole proprietor this number may be your Social Security Number.

SSN/F.E.I.N. Number: _____

Affidavit of Applicant

Read, sign, and date this Affidavit.

AFFIDAVIT AND SIGNATURE

This Application Must be Signed

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 of Authorized Person

Date of Signature (MM/DD/YY)

Printed Name and Title of Authorized Person