RI Department of Health
3 Capitol Hill, Room 104
Providence, RI 02908-5097
www.health.ri.gov

RI Department of Health

Application and Instructions for:

Competent Person

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 and the required documents to:

  Rhode Island Department of Health
  Office of Health Professionals Regulation
  Room 104 - 3 Capitol Hill
  Providence, RI 02908-5097

- Please note there is no fee for this license.

Documentation of Required Training	(A) Attach copies of certificate(s) indicating successful completion of an Agency approved fourteen (14) hour Competent Person training course

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 Health Professionals Regulation at 401-222-2828 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 printed on your License and reported to those that inquire about your License. Do not use nicknames, etc.	Name: _____ Prefix (Mr/Mrs/Dr.) First Name Last Name Suffix (Jr/III)
Date/Place of Birth:	Date of Birth: ☐☐ - ☐☐ - ☐☐☐☐ Month Day Year Place of Birth: _____
Gender:	Male ☐ Female ☐
Residence Information: It is your responsibility to keep the Department apprised of all address and phone number changes. **(Not published on the HEALTH web site**).	Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, ZipCode _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
Business/Employment Information:	Company Name _____ Address Line 1 _____ Address Line 2 _____ Address Line 3 _____ Address City, State, ZipCode _____ Address Country _____ Phone: _____ Fax: _____ Email Address: _____
SSN: **(Social Security Number)**	**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.** SSN: ☐☐☐ - ☐☐ - ☐☐☐☐

Competent Person Category: **(CHECK ONE ITEM ONLY)**	☐ Designated by Public Official ☐ Designated By Private Facility Indicate name and title of official making the designation, as well as the building(s) in which the applicant is responsible for any asbestos related activity. _____ _____
	☐ Undesignated Public Agency Indicate the basis for requesting said designation, as well as the building(s) for which said application is being made. _____ _____
	☐ Incidental to Primary Trade (Plumber, Oil Burner Repair, Etc.) ☐ Other (Specify)_____ Indicate the applicant's primary trade and the nature of asbestos related activity that the applicant proposes to engage in. If specific building(s) and/or types of buildings are known, they should also be identified. _____ _____
Enforcement Actions: **If Yes, please provide details. Attach a separate sheet if necessary**	1. Has any federal, state or local jurisdiction ever revoked or suspended any asbestos related license, certification and/or authorization held by the applicant? ☐ Yes ☐ No 2. Does any federal, state or local jurisdiction have outstanding enforcement action(s) against the applicant? ☐ Yes ☐ No _____ _____ _____ _____ _____ _____ _____
Affidavit of Applicant Read, sign, and date this affidavit.	**This Application Must be Signed by the Applicant** **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)**