

CASE #: _____
FUND CODE: 51600 51623 2135



DECONTAMINATION CONTRACTOR'S WORK PLAN

CONTRACTOR NAME: _____

Drug Lab Contractor License #: _____ Phone: _____ / _____ / _____

On-Site Personnel:

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

Name: _____ Title: _____

For additional contractor(s) and/or personnel, use additional sheet.

PROPERTY INFORMATION – Refer to OAR 333-040-0070(2)(a)(A).

Property Address: _____

Map and Tax Lot Information:

Township: _____ Range: _____ Section: _____ Tax Lot: _____

Owner Name: _____

Owner Address: _____

Directions to Property: (Check here if attached separately) _____

Date police records provided by OHA: _____

PROPOSED DECONTAMINATION PROCEDURE(S) – Refer to OAR 333-040-0070(2)(a)(E). (attach separately)

Anticipated Completion Date: _____ / _____ / _____

PROPOSED POST-DECONTAMINATION TESTING – Refer to OAR 333-040-0070(2)(a)(F). (Attach separately, or **check here** if post-sampling will be restricted to the areas that tested at or above the state standard in the initial sampling:)

Name of Person Taking Post-Decontamination Samples (if different from pre-sampling):

Laboratory Performing Post-Decontamination Analysis (if different from pre-sampling):

CERTIFICATION

Under penalties provided in ORS 453.888 and Oregon Laws 1999, chapter 861, I hereby certify the following:

1. That all personnel herein or otherwise listed with OHA have received the appropriate OSHA (29 CFR 1910.12[e] and OAR 437-02-100[18]) and OHA training, or meet the qualifications of Oregon Laws 1999, chapter 861 and OAR 333-040-0065, and
2. That all personnel herein and otherwise listed with OHA will wear appropriate protective clothing and equipment whenever at the property, and
3. That all of the information contained herein is true and accurate to the best of my knowledge, and
4. That work on this property may not begin until I receive approval from OHA.

Signature: _____

Date: _____

Signature of Supervisor

Name and Title/Position (typed/printed)

Mail this completed form and the review fee in the form of a check or money order for \$900 (\$100 for vehicles) payable to the STATE OF OREGON to: OREGON HEALTH AUTHORITY, Business Services, PO Box 14260, Portland OR 97293-0450. **Send a copy of this form and copy of the check, along with the work plan to:** OREGON HEALTH AUTHORITY, Attn: Drug Lab Specialist, 800 NE Oregon Street, Suite 640, Portland, OR 97232. **Please Note:** Under OAR 333-040-0180 (5), all fees are non-refundable unless the applicant submits a written request to withdraw the application within ten days