

## DRUG LAB DECONTAMINATION CONTRACTOR REFRESHER TRAINING APPLICATION

BUSINESS NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

OWNER OR PRINCIPAL NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DRUG LAB CONTRACTOR LICENSE #: \_\_\_\_\_

CCB GENERAL CONTRACTOR LICENSE #: \_\_\_\_\_

| PERSONNEL INFORMATION (Attach a second sheet if necessary): |  |         |                  |
|---|--|---------|------------------|
| NAME  | CERTIFICATION  | BADGE # | BADGE ISSUE DATE |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |
|   | <input type="checkbox"/> Worker<br><input type="checkbox"/> Supervisor |         | ____/____/____   |

I declare under penalty of perjury and the provisions of ORS 453.888 that I have examined this application and all attachments, and to the best of my knowledge and belief the enclosed information is true, correct, and complete. I will notify the Oregon Health Authority of any changes in this information within 30 days of any such change.

\_\_\_\_\_  
SIGNATURE (Owner or Principal)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
NAME (please print)

| FEE DESCRIPTION          | INDEX | PCA   | OBJECT | COST PER PERSON | NUMBER OF ATTENDEES | TOTAL |
|--------------------------|-------|-------|--------|-----------------|---------------------|-------|
| Recertification Training | 50207 | 52361 | 2381   | \$100.00        |                     |       |

Please enclose the total dollar amount in the form of a check or money order payable to the **STATE OF OREGON**, and send it to: **Oregon Health Authority, Business Services, P.O. Box 14260, Portland, OR 97293-0450.**

**PLEASE NOTE:**

Under OAR 333-040-0180(5), no portion of the above fees is refundable unless the fee was submitted in error and the application is withdrawn by written request on the applicant within 10 working days of submission.

**Don't forget to include:**

- Signed Application
- Check or Money Order
- Current 8-Hour Hazwopper Refresher Certificate for each employee