APPLICATION FOR A SERVICE PROVIDER REGISTRATION

ASHLAND COUNTY HEALTH DEPARTMENT
1211 CLAREMONT AVE
ASHLAND, OH 44805
Phone: 1-419-282-4275 Fax: 1-419-282-4333

Business Name: _____ Date: _____

Operator's Name: _____ ID #: _____

Street Address: _____ Fee: 150.00

City, State, Zip: _____

Phone: _____ Cell Phone: _____ Pager: _____ Fax: _____

E-Mail: _____

Bond Company: _____ Bond Expiration Date: / / _____

Types of Systems/Components Serviced: _____

_____

_____

_____

_____

Registered also in: List County Health Dept(s)

_____

Employee(s) authorized to conduct services or labor under your supervision.

_____

List Manufacturer/Distributer training, certification, and/or qualifications.

_____

Upon submittal of a completed application and application fee of $150, the Health Department shall review the application and issue a certificate of registration within thirty (30) days of receipt. No registration is valid until the certificate is issued. Such registration shall remain VALID UNTIL THE LAST DAY OF DECEMBER OF EACH YEAR or only so long as the work performed is satisfactory to the Health Commissioner.

_____

Verification of testing/competency requirements (6 hours continuing education)

I hereby agree to comply with Chapter 3701-29 of the Ashland County Board of Health Sewage Treatment/Disposal System rules and all applicable provisions.

APPLICANT _____ DATE. _____

(SIGNATURE)

(Office Use Only)

YEAR _____ ☐ Registration Approved: ____ ☐ Registration Denied: ____ ☐ Insurance

Test Date: / / _____ Score: _____ ☐ CEUs Attached ☐ Bond Attached

DATE _____ RECEIPT # _____ Received by: _____