

Decommissioning Notification Stage II Vapor Recovery

MUST BE SUBMITTED AT LEAST SEVEN (7) DAYS PRIOR TO DECOMMISSIONING

A. IDENTIFICATION

Station Site Name		Station Owner Name:	
Site Street Address:		Mailing Address:	
City/Town:		City/Town:	
State:	Zip Code:	State:	Zip Code:
Telephone Number:		Telephone Number:	

B. Facility ID Number: _____

C. Throughput per year: _____
million (MM) gallons per year

D. Type of System: Vaccuum-Assist Balance Aspirated

Tank top accessible with excavation: YES NO

Decommissioning Company Name (please print): _____ Decommissioning Date: _____

Technician Signature: (Note: Signer is verifying that system will be decommissioned following the PEI 300-09 - Chapter 14 standard.) _____ Date: _____

Station Owner Representative Name (please print): _____

Station Owner Representative Signature: _____ Date: _____

Certification, checklist and test report must be submitted 30 business days after decommissioning.
Forms are available on RI DEM's website at <http://www.dem.ri.gov/pubs/forms.htm#air>

Send Completed Form To:

State of Rhode Island
Department of Environmental Management
Office of Air Resources
235 Promenade Street, Room 230
Providence, RI 02908
Phone: 401-222-2808
Fax: 401-222-2017