



RI DEM Certified UST Operator Registration Form

This form must be submitted with copies of certification for all operators. **ALL** fields must be complete. If the same Class A/B operator information applies to more than 3 UST facilities with the same owner, please fill out one form and submit a list of facilities to which the information applies. Submit to:

DEM-3rd Floor Office of Waste Management
Attn: Jillian Thompson
235 Promenade Street
Providence, RI 02908

Facility Name:	Facility UST #:
Facility Address:	Current Operating Status: <input type="checkbox"/> Active <input type="checkbox"/> Temporarily Closed
Facility Phone #:	
DESIGNATED CLASS A OPERATOR	
Operator's Name:	Relation to UST Facility <input type="checkbox"/> Owner <input type="checkbox"/> Operator <input type="checkbox"/> Employee <input type="checkbox"/> Third-Party
Operator's Phone #:	
Operator's Mailing Address:	E-mail:
Certification State: Certification #:	Cert. Issue Date:
DESIGNATED CLASS B OPERATOR <input type="checkbox"/> Same as CLASS A	
Operator's Name:	Relation to UST Facility <input type="checkbox"/> Owner <input type="checkbox"/> Operator <input type="checkbox"/> Employee <input type="checkbox"/> Third-Party
Operator's Phone #:	
Operator's Mailing Address:	E-mail:
Certification State: Certification #:	Cert. Issue Date:
ADDITIONAL CLASS A and/or B OPERATORS (optional) <input type="checkbox"/> CLASS A <input type="checkbox"/> CLASS B	
Operator's Name:	Relation to UST Facility <input type="checkbox"/> Owner <input type="checkbox"/> Operator <input type="checkbox"/> Employee <input type="checkbox"/> Third-Party
Operator's Phone #:	
Operator's Mailing Address:	E-mail:
Certification State: Certification #:	Cert. Issue Date:
I certify that, for the facility indicated at the top of this page, the individual(s) listed above will serve as the designated certified Class A and/or Class B UST Operator(s).	
NAME OF FACILITY OWNER (Please Print): _____	
SIGNATURE OF FACILITY OWNER: _____	
SIGNATURE OF CLASS A OPERATOR: _____	
SIGNATURE OF CLASS B OPERATOR: _____	
DATE: _____ OWNER'S PHONE #: _____	

YOU MUST NOTIFY THIS OFFICE OF CHANGES TO ABOVE INFORMATION 30 DAYS PRIOR TO THE CHANGE TAKING PLACE