

STATE OF CONNECTICUT

DEPARTMENT OF PUBLIC HEALTH

STATE USE ONLY							
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APPLICATION FOR ALTERNATIVE WORK PRACTICES

Please provide the following information as required by the Regulations of Connecticut State Agencies, Section 19a-332a-11. Be sure to note if there are attachments. An incomplete application will result in a delayed response. Fee for application is \$200, payable to "Treasurer, State of Connecticut". Allow ten days to review application, except for emergency applications. Application may only submitted by a licensed asbestos project designer.

1. PROJECT DESIGNER INFORMATION

Application Date:	Inspection Date:						
Name of Project Designe	r						
License #	Expiration Date		PD_Phone #				
PD Address							
PD City, State, Zip Code							
Signature							
2. PROPERTY INFORM							
Facility Owner							
Owner Address							
Owner Phone	0_	_Contact Pe	rson				
PROJECT NAME & ADDRESS P	roject						
City/State /Zip							
3. ASBESTOS ABATE	MENT CONTRACTOR INFO	RMATION (IF KNOWN)				
Asbestos Abatement Cor	ntractor			CT License #	ŧ		
C_Address							
C_City, State Zip Code							
Contractor Phone		C_Contact P	erson				
4. PROJECT SUMMAR	Υ						
Nature of Abatement	Renovation Demolition Start Date (if known)						
Type of Asbestos Abater	nent Removal	Enclosur	e Encar	osulation	Spot Repair		
Type and Amount of Asbe	estos Material Pertaining to AV	VP (Use ad	lditional attach	ment if neces	ssary)		
Flooring (Specify (FT²)	Mastic Cement Boo	ard(FT²)	Other Non-Fria	ble (specify)			
Caulking (LF) specify	Pipe Insulation (LF)	Pipe Fitting	gs (each)	Other Friabl	e (specify)		



Phone: (860) 509-7367, Fax: (860) 509-7378 Telephone Device for the Deaf (860) 509-7191 410 Capitol Avenue - MS #12-AIR P.O. Box 340308 Hartford, CT 06134 An Equal Opportunity Employer



5. DESCRIPTION OF FACILITY

Building Data	Size	Age	Current Facility Use	

Square Feet

Estimate, if unknown

6. SPECIFIC ALTERNATIVE WORK REQUEST

Section(s) and Subsections of the Standards for Asbestos Abatement regulation for which alternative work practice(s) is/are proposed:

Description of Alternative Work Practice(s): Please provide additional information such as drawings, photographs, work plans or similar information in order to provide an accurate review. Please identify the specific work area/s of the facility.

Application Status

DPH STAFF

REVIEWED BY

DATE

APPROVED/ DENIED/ SET ASIDE

MAIL COMPLETED FORM TO: DEPARTMENT OF PUBLIC HEALTH - EHS

410 CAPITOL AVE, MS# 12 AIR PO BOX 340308 HARTFORD, CT 06134-0308

Please note, payment for all emailed applications is due within five days.