



# STATE OF CONNECTICUT

## DEPARTMENT OF PUBLIC HEALTH

### APPLICATION FOR ALTERNATIVE WORK PRACTICES

STATE USE ONLY	
Date	
Received	
Check #	
Trans #	
Entered	

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

Date of Application

Inspection Date:

Name of Project Designer

License #

Expiration Date

PD Phone #

PD Address

PD City, State, Zip Code

Signature

#### 2. PROPERTY INFORMATION

Facility Owner

Owner Address

Owner Phone

O Contact Person

#### PROJECT NAME & ADDRESS

Project City/State /Zip

#### 3. ASBESTOS ABATEMENT CONTRACTOR INFORMATION (IF KNOWN)

Asbestos Abatement Contractor

CT License #

C Address

C City, State Zip Code

Contractor Phone

C Contact Person

#### 4. PROJECT SUMMARY

Nature of Abatement

Renovation

Demolition

Type of Asbestos Abatement

Removal

Enclosure

Encapsulation

Spot Repair

Start Date (if known)

Type and Amount of Asbestos Material Pertaining to AWP (Use additional attachment if necessary)

Flooring (Specify (FT <sup>2</sup> ))	Mastic (FT <sup>2</sup> )	Cement Board(FT <sup>2</sup> )	Other Non-Friable (specify)
Caulking (LF) specify	Pipe Insulation (LF)	Pipe Fittings (each)	Other Friable (specify)

## 5. DESCRIPTION OF FACILITY

## 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.

### DPH STAFF

## Status Application

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.**