

APPLICATION TO BECOME AN APPROVED TRAINING PROVIDER

Mail original to DEQ – Keep copy for your files

Instructions: Complete this form and return it to the **Department of Environmental Quality Water/Wastewater Operator Certification Office at PO Box 200901, Helena MT 59620-0901**. Your applications will be reviewed and a determination will be made. A provider must reapply and be approved every two years, concurrent with the CEC biennium. TO HELP IN THE EVALUATION PROCESS, PLEASE ATTACH PREVIOUSLY APPROVED CLASSES WITHIN THE LAST CEC PERIOD.

TRAINING PROVIDER: _____

ORGANIZATION: _____

CONTACT PERSON: _____

MAILING ADDRESS: _____

PHONE NUMBER: _____ FAX NUMBER: _____

PRINCIPAL GOAL OF ORGANIZATION (TRAINING SECTION):

TYPES OF TRAINING PROVIDED:

COURSE WILL BE APPLICABLE TO:

- | | |
|--|---|
| <input type="checkbox"/> ALL CERTIFIED OPERATORS | <input type="checkbox"/> WELL WATER SUPPLY OPERATORS |
| <input type="checkbox"/> WATER DISTRIBUTION OPERATORS | <input type="checkbox"/> WASTEWATER TREATMENT PLANT OPERATORS |
| <input type="checkbox"/> WATER TREATMENT PLANT OPERATORS | <input type="checkbox"/> WASTEWATER LAGOON OPERATORS |

PERSONS AUTHORIZED TO MONITOR AND VERIFY ATTENDANCE OR COURSE COMPLETION:

NAME: _____ NAME: _____

TITLE: _____ TITLE: _____

PHONE: _____ PHONE: _____

IT IS AGREED that the above information is accurate. **IT IS AGREED** that the laws, rules, guidelines, and course criteria, as well as the Montana Approved Training Providers Code of Ethics required by the Montana Operator Certification Program will be followed. **THE TRAINING ORGANIZATION IS AWARE** that all records will be made available to a member of the DEQ upon request; and this approval is for a two-year period which must be re-applied for every two years coinciding with the current CEC biennium. If any of the above requirements are not met, the approved training provider status shall be revoked.

AUTHORIZED SIGNATURE: _____ DATE: _____

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