

CHANGE OF OWNER OF DISPENSING STATION FACILITY

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
MAINE FUEL BOARD
35 State House Station
Augusta, ME 04333
Tel. (207)624-8606, Fax (207)624-8636

NEW NAME OF FACILITY			
ADDRESS OF FACILITY			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FEDERAL I.D. NUMBER		

FORMER NAME OF FACILITY			
CITY	STATE	ZIP	COUNTY

NAME OF OWNER OF DISPENSING STATION EQUIPMENT			
ADDRESS OF OWNER			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FAX # ()	LICENSE #	
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional & Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.			
SIGNATURE		DATE	

CHANGE OF LIMITED OPERATOR APPLICATION

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
MAINE FUEL BOARD

35 State House Station, Augusta, ME 04333
Tel. (207)624-8606, Fax (207)624-8636

PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE DISPENSING STATION OWNER TO ENSURE THAT LIMITED OPERATORS ARE REGISTERED WITHIN 14 DAYS OF HIRE IN ORDER TO DISPENSE PROPANE. OPERATOR TRAINING SHALL OCCUR ON AN ANNUAL BASIS.

LIMITED OPERATOR INFORMATION (please print)			
FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	- -
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ()	FAX # ()	DATE OF HIRE	
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information and that this information is truthful and factual.			
SIGNATURE		DATE	

DISPENSING STATION INFORMATION (please print)			
NAME OF FACILITY			
MAILING ADDRESS OF FACILITY			
CITY	STATE	ZIP	COUNTY
DISPENSING STATION LICENSE #			

IF YOU ARE CURRENTLY LICENSED AS A PLANT OPERATOR AND/OR DELIVERY TECHNICIAN YOU DO NOT NEED TO COMPLETE THE FOLLOWING AFFIDAVIT.

I am currently licensed as a: Plant Operator Delivery Technician — License #: _____

AFFIDAVIT	
I hereby certify that _____ has	
(Name of Limited Operator)	
been properly trained as the Limited Operator in accordance with 32 MRS §18142(2)(B).	
Date: _____	_____
	Signature of Limited Operator

	Facility Name Typed or Printed
Date: _____	_____
	Signature of Training Representative

	Training Representative Name Typed or Printed

	Company Name of Owner of the Filling Equipment