APPLICATION FOR A SERVICE PROVIDER REGISTRATION

PERRY COUNTY HEALTH DEPARTMENT
PO BOX 230
NEW LEXINGTON, OH 43764
Phone: 1-740-342-5179 Fax: 1-740-342-5540

Business Name: _____ Date:

Operator's Name: _____ ID #: _____

Street Address: _____ Fee: _____

City, State, Zip: _____

Phone: _____ Cell Phone: _____ Pager: _____ Fax: _____

E-Mail: _____

Bond Company: _____ Bond Expiration Date: / / _____

Types of Systems/Components Serviced: _____

I/We hereby apply for a permit to be a SERVICE PROVIDER in Perry County during the year of 2024.
I agree to comply with all regulations of the Board of Health of the Perry County Health Department. Chapter 3701-29-01 through 3701-29-23 of the Ohio Administrative Code - Registration of Service Providers and acknowledge that my registration may be suspended or revoked for violation of any provision of these code sections.

OAC CHAPTER 3701-29-03 THE ANNUAL FEE FOR A SERVICE PROVIDER SHALL BE $57.00.
The Ohio Department of Health and The Perry County Health Department Requires $25,000 Surety Bond before application will be approved. A copy must be supplied to The Ohio Department of Health and The Perry County Health Department. You must also provide proof of passing the statewide STS Exam before regestration will be approved.

SUCH REGISTRATION SHALL REMAIN VALID UNTIL December 31 OF EACH YEAR OR ONLY SO LONG AS THE WORK PERFORMED IS SATISFACTORY TO THE HEALTH COMMISSIONER.

BONDING COMPANY _____

APPLICANT _____ DATE. _____
(SIGNATURE)

(Office Use Only)

YEAR 2024 ☐ Registration Approved: ____ ☐ Registration Denied: ____ ☐ Insurance

Test Date: / / _____ Score: _____ ☐ CEUs Attached ☐ Bond Attached

DATE _____ RECEIPT # _____ Received by: _____