



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 any attachments. An incomplete application will result in a delayed response.

1. PROJECT DESIGNER INFORMATION

Date of Application					
Name of Project Designer					
License #		License Expiration Date		Phone #	
Address					
City, State, Zip Code					
Signature					

2. PROPERTY INFORMATION

Facility Owner					
Address					
Phone		Contact Person			
Address of Facility					
City, State and Zip Code					

3. ASBESTOS ABATEMENT CONTRACTOR INFORMATION (IF KNOWN)

Asbestos Abatement Contractor				CT License #	
Address					
City, State Zip Code					
Phone		Contact Person			

4. PROJECT SUMMARY

Nature of Abatement	Renovation	<input type="checkbox"/>	Demolition	<input type="checkbox"/>	Both	<input type="checkbox"/>		
Type of Asbestos Abatement	Removal	<input type="checkbox"/>	Enclosure	<input type="checkbox"/>	Encapsulation	<input type="checkbox"/>	Spot Repairs	<input type="checkbox"/>
Start Date (if known)								
Type and Amount of Asbestos Material Pertaining to AWP					(Use additional attachment if necessary) fill in below			
Floor Tile (FT ²)	Linoleum (FT ²)	Transite (FT ²)	Other Non-Friable (specify)					
Window Caulking (LF)	Pipe Insulation (LF)	Pipe Fittings (each)	Other Friable (specify)					



Phone: (860) 509-7367, Fax: (860) 509-7378
 Telephone Device for the Deaf (860) 509-7191
 410 Capitol Avenue - MS #51-AIR
 P.O. Box 340308 Hartford, CT 06134
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5. DESCRIPTION OF FACILITY

Building Data	Size		Age		Facility Use	
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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.

DPH STAFF

Application Status

REVIEWED BY	DATE	APPROVED/ DENIED/ SET ASIDE

MAIL COMPLETED FORM TO:

DEPARTMENT OF PUBLIC HEALTH - EHS
 410 CAPITOL AVE, MS# 51 AIR
 PO BOX 340308
 HARTFORD, CT 06134-0308