DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Office of Drinking Water

Certified Drinking Water Operators Application

- *Please place an "X" in the appropriate box indicating which type of license you are applying for:*

☐ Water Operator License ☐ Operator In Training License

☐ Reciprocal License ☐ Limited License (Daycare/School)

- *Please print or type:*

Name: Social Security # - -

First MI Last

Home Address:

No. and Street

City State Zip Code

Home Phone No. Work Phone No.

Area Code Area Code

E-Mail Address:

*NOTE: Under the Federal Privacy Act 5, USC 552a, disclosure of your social security number is voluntary. It will be used for the purpose of a unique internal identifier.

Have you previously filed an application for a license with the Division of Public Health? ☐ Yes ☐ No

Have you taken a Division of Public Health examination for water operator licensing? ☐ Yes ☐ No

Score: Date Taken:

EDUCATION

Do you have a high school diploma or equivalency certificate (GED)? ☐ Yes ☐ No

Do you have a college degree? (optional) ☐ Yes ☐ No

Name & Location of college	Dates Attended		Major	Degree
	From	To		

<u>Drinking Water System Employment Record</u> (Begin with present position and work back through applicable experience)

NAME OF PUBLIC WATER SYSTEM AT WHICH YOU ARE OR EXPECT TO BE EMPLOYED:

Name of Employer				
Address & Phone Number				
Position/Title			**Dates of Employment**	
			From:	**To:**
Treatments				
Have these treatments been in place the entire time you have worked there?				**Yes** ☐ **No** ☐
☐ **Full Time**	**If part time, give the number of hours worked per week:**	**Time Employed**		
		Direct Responsible Charge*	**Operating Experience****	
☐ **Part Time**		**Yrs. Mos.**	**Yrs. Mos.**	

This section below is to be completed by the applicant's current supervisor

To the best of my knowledge, I certify that the above information is factual and accurate

Printed Name	Supervisor's Signature	Date

PREVIOUS WATER SYSTEM EMPLOYMENT:

Name of Employer				
Address & Phone Number				
Position/Title			**Dates of Employment**	
			From:	**To:**
Treatments				
Have these treatments been in place the entire time you have worked there?				**Yes** ☐ **No** ☐
☐ **Full Time**	**If part time, give the number of hours worked per week:**	**Time Employed**		
		Direct Responsible Charge*	**Operating Experience****	
☐ **Part Time**		**Yrs. Mos.**	**Yrs. Mos.**	

***Direct Responsible Charge** means a certified water system operator assigned accountability for performance of active, on-site operational duties.

****Operator** means a licensed person who works in a water treatment facility and/or a water distribution system who may be a direct responsible charge or may work under a direct responsible charge.

Base Level License Includes:	
Disinfection Hypochlorination	**Distribution** Flow < 500 gpm at 20 psi

Applicants applying for a Reciprocal License need to fill out the information in the area below

Applicants must provide a copy of their current license/certificate and provide a copy of that State's licensing requirements

State in which licensed and current classification	License #

ACKNOWLEDGEMENT (read this section carefully)

I, the undersigned, certify that I am the above applicant; that all statements made and information contained in this application are true and correct to the best of my knowledge and belief; that I understand that any omissions of misrepresentations may result in ineligibility for certification or revocation of any certificate granted. I understand that the enclosed fee is non-refundable. Further, should I have received the certification under false circumstances, I will immediately surrender the certificate to the Division of Public Health, Office of Drinking Water. I also consent to a thorough investigation of my application for the purpose of verification of my qualifications for certification. I also understand that by signing below I give the Division of Public Health, Office of Drinking Water the authority to use and report this information and my test results for statistical and demographic purposes only. I waive all claims and agree to indemnify and hold harmless the Division of Public Health, Office of Drinking Water for any action taken pursuant to the rules and standards of the Division of Public Health, Office of Drinking Water with regard to my application and / or my certification except claims based on gross negligence or lack of good faith.

Signature of applicant	Date

IMPORTANT: *Read carefully before submitting your application.*

- Have you answered all of the questions? Please check to make sure you have completed the application.
- Have you signed and dated the application above?
- Has your current supervisor signed and dated the appropriate employment block?
- Have you provided all necessary documentation?
- Incomplete applications will be returned.
- Send you application and all necessary documentation to:

Division of Public Health
Office of Drinking Water
Blue Hen Corporate Center
Suite 203, 655 Bay Road
Dover, DE 19901

Doc. No. 35-05-20/07/08/03

DO NOT WRITE IN THE SECTION BELOW

DO NOT REMOVE THIS PAGE – FOR ADVISORY COUNCIL USE ONLY

				Approved?	
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No

Secretary or designee approval: Yes ☐

No ☐ Date:

Comments: ____

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Second Submittal

				Approved?	
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No
Reviewed By:	______________ Printed Name	______________ Date Reviewed	______________ Initials	☐ Yes	☐ No