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

PHONE: (302) 741-8630
FAX: (302) 741-8631

DRINKING WATER OPERATOR LICENSE APPLICATION

Check the license for which you are applying:

☐ Base-level Water Supply Operator: Requires High School Diploma or equivalent and one year of acceptable operating experience; or three years of acceptable operating experience and successful completion of the base-level license written examination. The Base-level License includes disinfection (hypochlorination), distribution (<500 gpm at 20 psi), and Approved Sampler/Tester endorsements.

☐ Operator-in-Training (OIT): A water treatment OIT who lacks either the education or experience requirements for a Base-level License may receive an interim OIT License for a maximum of one year, pending successful completion of the base-level license written examination. An OIT licensee must be employed at a water system performing the duties of an operator consistent with the definition of operator in these regulations continuously for one year before becoming eligible for a Base-level License.

☐ Distribution: A distribution system operator may obtain a Distribution License when they are responsible for oversight of a distribution system and have no responsibilities for operations at the treatment plant.

☐ Reciprocal: To receive reciprocity from another state, the applicant must provide a copy of their current license/certificate and provide a copy of that state's licensing requirements.

1. Name:_____
   (last) (first) (middle initial)
2. Home address:_____
   City: _____ State: _____ Zip Code:_____
3. Home phone: _____ Work phone: _____ Cell phone:_____
4. Email address: _____
5. Do you have a high school diploma or equivalency certificate (GED)? Yes ☐ No ☐
6. Have you previously filed an application for a water operator license with the Division of Public Health? Yes ☐ No ☐
7. Have you taken an examination for the water operator license? Yes ☐ No ☐
   Date exam was taken*: _____ Score: _____
   **Attach proof of attendance/exam score to this application.*

PUBLIC WATER SYSTEM (PWS) CURRENT EMPLOYMENT INFORMATION

1. Name of PWS at which you are employed or expect to be employed: _____
2. Name of employer if different from PWS name: _____
3. PWS ID number: _____
4. PWS address: _____
5. PWS phone number: _____
6. Position/title: _____
7. Are you currently employed at this PWS? Yes ☐ No ☐
8. Employment status: Full-time ☐ Part-time ☐ Part-time hrs/week: _____
9. Date of Hire: _____
10. Specific duties _____
11. Treatments:

A. DISINFECTION ☐ Hypochlorination* Gas Chlorination Ozonation (Reserved) (Reserved) Chloramines Chlorine Dioxide UV Light	**B. CHEMICAL FEED** ☐ Lime-Soda Ash pH Adjustment Inhibitor* Sequestering Permanganate (Reserved) Fluoridation	**C. FILTRATION** ☐ Activated Carbon* Sand* Reverse Osmosis Greensand Activated Alumina Ion Exchange Cartridge (Reserved) Ultrafiltration Microfiltration
D. SURFACE WATER ☐ Algae control Coagulation Flocculation Rapid Mix Sedimentation Sludge Treatment	**E. OTHER TREATMENTS** ☐ Aeration* Dechlorination* Distillation (Reserved) Electrodialysis	**F. DISTRIBUTION** ☐ Flow <500 gpm at 20 psi Flow >500 gpm at 20 psi
G. Approved Sampler Tester ☐		

12. Have these treatments been in place the entire time you have worked there?

Yes ☐ No ☐ N/A ☐

This Section to be completed by the applicant's current Direct Responsible Charge (DRC) *To the best of my knowledge, I certify that the above information is factual and accurate*			
Printed name	DRC's signature	Phone number	Date

PWS PREVIOUS EMPLOYMENT INFORMATION (if applicable)

13. Name of employer: _____
14. PWS ID number: _____
15. PWS address: _____
16. PWS phone number: _____
17. Position/title: _____
18. Dates of employment. From: _____ To: _____
19. Previous employment: ☐ Full-time ☐ Part-time Part-time hrs/week: _____
20. Specific duties: _____
21. Treatments: _____

    _____
22. Were these treatments in place the entire time you worked there?

    Yes ☐ No ☐ N/A ☐

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 #

IMPORTANT

Read carefully before submitting your application:

- Have you answered all the questions? Check to make sure you have completed the application.
- Have you signed and dated the application?
- Has your DRC signed and dated the appropriate employment block?
- Have you provided all necessary documentation?
- Incomplete applications will be returned.
- Submittal cut off date to be reviewed is 14 working days prior to the Advisory Council Board meetings.

Submit this completed form to: Office of Drinking Water 43 South DuPont Highway Dover, DE 19901
FAX: 302-741-8631

OR Via email to: DHSS_DPH_OpCert@delaware.gov

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)

OFFICIAL USE ONLY

Approved: Yes ☐ No ☐

Reviewed by: _____

Date of review: _____

Initials: _____