



LEAD FIRM CERTIFICATION APPLICATION

HOW TO APPLY

1. Complete this form in black or blue ink only. Only originals will be accepted. **Allow 2-4 weeks for processing.**
2. Include a \$100 certification fee in the form of a business check, cashier's check or money order made payable to the MN Department of Health. Fees are nonrefundable. **A service fee will be charged for returned checks.**
3. Attach a copy of workers' compensation certificate of insurance with the following criteria: the name of the insurance company, policy number, dates of coverage, MN Department of Health, Lead Program, PO Box 64975, St. Paul, MN 55164 as the certificate holder, and a 30-day written notice to the certificate holder if the policy is canceled before the expiration date of the policy. If self-insured include permit to self-insure. If no employees or employees not covered by the worker's compensation law, include a signed and dated letter stating this.
4. **Mail to:** MN Department of Health, Asbestos/Lead Compliance Unit, PO Box 64497, St Paul, MN 55164-0497. Questions? Call 651-201-4620 or visit our website at <http://www.health.state.mn.us/lead>.

IMPORTANT: MDH Lead Certification **DOES NOT** meet the regulatory requirements of the U.S. EPA's Renovation, Repair and Painting (RRP) Rule. You must apply to the U.S. EPA to comply with the RRP Rule requirements.

GENERAL INFORMATION

Select one of the following application types

- Initial certification
- Re-certification

Check all that apply to be listed on Minnesota Department of Health's website for

- Consultant (your company performs paint inspections, lead risk assessments, clearance inspections)
- Contractor (your company performs lead abatement)
- Contractor-Lead Orders (your company will perform lead abatement to complete lead orders issued by a public health agency, such as MDH, City of Minneapolis, St. Paul/Ramsey County, etc.)

LEAD FIRM INFORMATION

1. Company Name _____
2. Business Address _____
3. City _____ 4. State _____ 5. ZIP _____ 6. County _____
7. Name of Business Contact _____
8. Business Phone # (____) - ____ - _____ 9. Fax # (____) - ____ - _____
10. Email Address _____
9. Minnesota Tax # _____ 10. Federal Employer # _____
(Required by MN Statutes, §270C.72)

SIGNATURE

I declare that all the information I have provided is true and complete and that I have read and understand the department's Tennessee Warning. The Tennessee Warning is available by calling 651-201-4620 or from the department's website at <http://www.health.state.mn.us/divs/eh/lead/prof/forms/index.html> I understand that submitting false information is grounds for denying, or suspending, revoking or taking other disciplinary action against this certification as specified in Minnesota Statutes, section 144.992.

Signature _____ Date _____ / ____ / ____
mm/dd/yyyy