New Mexico Environment Department
Environmental Health Bureau
Liquid Waste Program

Maintenance Service Provider Qualification Certificate Application Part A

Applicant Information

Name of Applicant (Last, First)		*Name of Company*	
Mailing Address		*Company Mailing Address*	
City, State	*Zip*	*City, State,*	*Zip*
Phone Number		*Company Contact Name and Phone Number:*	
Email Address		*Company Email Address*	

Which Certifications are Current and Active? *(Attach all certifications with this application)*

Certification by the Manufacturer	***Manufacturer:***	***Manufacturer:***
NM Operator Certification for Small Advanced Wastewater Systems (Or higher)		***Certificate # and Exp date:***
Certification as Wastewater Operator from another state	***State:***	***Certificate # and Exp date:***
Other Certification based on Credentials Approved by the Department:		***Approval Date:***

Name All Proprietary Advanced Treatment Systems that you are applying for Qualification under 904(C) of Liquid Waste Regulations 20.7.3 NMAC (NOTE: You must submit a "PART B" for each and every ATS that you are requesting approval to service)

For each of the Advanced Treatment Systems listed above, you must fill out an "ATS QUALIFICATION FORM" for each ATS. Qualification Forms are Attached?	**YES**	**NO**
Do you have the ability to sample all units using manufacturer's sampling protocol?	**YES**	**NO**
Will you be able to respond to emergency situations within 48 hours of being notified?	**YES**	**NO**
Do you use a contract for service that contains, at least, minimum standards approved by NMED?	**YES**	**NO**
Do you have a quality assurance/quality control plan acceptable to the department?	**YES**	**NO**
Will you notify NMED within 5 working days for any failed system?	**YES**	**NO**

By signing below, I acknowledge that I have read the Liquid Waste Disposal and Treatment Regulations and I understand the sections of the regulations that pertain working as a maintenance service provider. I understand that should I be approved as a maintenance service provider on specific advanced treatment units, that I must be on-site for all activities involving the maintenance of these advanced treatment systems.

Printed Name:	*Signature*	*Date*

NMED LIQUID WASTE QUALIFICATION CERTIFICATE FEE ☐ *Maintenance Service Provider Qualification Certificate $50*

Total Fee Paid	***Check number***	***Date Paid***	***Payment Received By***

Please Complete this Application Form(Part A) along with Part B Forms for each ATS you want to work on to : Michael Broussard, EHB Liquid Waste Program, 2450 Camino Edward Ortiz, Santa Fe, NM 87505; Fax 505-827-1839 Michael.Broussard@state.nm.us or 505-476-9125

Please note that the certificate of registration belongs ONLY to the trained applicant as approved and registered. It does not belong to the company. The company name is associated with our records for administrative purposes. Anapproved individual must be at the site of any maintenance activity.

Maintenance Service Provider	☐ ***Approved***	☐ ***Denied***	☐ ***Incomplete***

Applicant notification, date, via, provide comments:

Approved Date:	***Certificate Number:***	***Qualification Expiration Date:***
NMED Official Name Printed:	***NMED Official Signature:***	***Date:***

New Mexico Environment Department
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Maintenance Service Provider Qualification Certificate Application Part B

MSP Application-ATS Qualification Form (Part B)

You must submit a separate "Part B" for <u>each</u> type of advanced treatment system(ATS) that you are requesting t to service. Fill out one form for each Manufacture and include all model numbers. The department will determine whether you meet the regulatory requirements and will send you a letter informing you that you have been approved or denied for maintaining this system. For all systems that you are approved to operate, service and maintain , your name will be listed on the NMED website.

Applicant Information

Name of Applicant (Last, First)		*Name of Company*	
Mailing Address		*Company Mailing Address*	
City, State	*Zip*	*City, State,*	*Zip*
Phone Number		*Company Contact Name and Phone Number:*	
Email Address		*Company Email Address*	

1. Name of Advanced Treatment Unit(s) you are requesting to inspect, operate and maintain *(Include Name of Manufacturer, Series Name and Model Numbers)*

Have you completed a training and certification program from the manufacturer on this ATS?	**Date of the last training you attended for this ATS?**	**YES**	**NO**
a. If You Answered YES to the question above	**Please submit all certifications as part of this application**		

b. ***If You Answered <u>NO</u> to the question above you are required to answer the below listed questions.***

3. You must provide a written statement that describes trainings that you have received on similar types of ATSs and describe your experience at operating, maintaining and servicing these units. <u>Is this statement attached?</u>		**YES**	**NO**
4. Do you have operation and maintenance manuals for this ATS that would be made available for NMED verification?		**YES**	**NO**
5. Do you have regular access to replacement parts for this ATS?		**YES**	**NO**
6. If the operation and maintenance of this ATS requires specialized tools, do you have access to these tools?	**N/A**	**YES**	NO

By signing below, I agree that the foregoing information is true and correct to the best of my knowledge.

Printed Name:	*Signature*	*Date*

Maintenance Service Provider ATS Qualification	☐ ***Accepted***	☐ ***Denied***	☐ ***Incomplete***

Applicant notification, date, via, provide comments:

Approved Date:	***Certificate Number:***	***Qualification Expiration Date:***
NMED Official Name Printed:	***NMED Official Signature:***	***Date:***