MAINE CDC DRINKING WATER PROGRAM
Department of Health & Human Services
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ANNUAL CREMATORIUM REPORT

Please complete all of the following data components. Please print legibly or type.

FACILITY INFORMATION

Facility Name _____

Facility Location Street: _____ Town/City: _____

Facility Mailing Address Street/PO Box: _____

Town/City: _____ State: _____ Zip: _____

Facility Operator/Authority _____

Telephone: _____ E-mail: _____

OPERATIONS SUMMARY

1. Reporting Period: Fiscal ☐ Calendar ☐ year ending on _____
(MM/DD/YYYY)

2. During this reporting period, did any changes to the organization, the structure, and/or the equipment used at the subject facility change? Yes ☐ No ☐

   If "yes," please provide a detailed description on a separate page or pages.

3. Monthly totals for number of human remains processed:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
Number Processed													

I, _____, Facility Operator/Authority for the subject facility, hereby state
Print Name
that this report is accurate to the best of my knowledge. I further stipulate that I am aware that deliberate falsification of the information herein shall be sufficient cause for an audit of the subject facility's records.

_____ _____
Signature of Facility Operator/Authority *Date*