CHANGE OF OWNER OF DISPENSING STATION FACILITY (Rev. 08/2016)

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
MAINE FUEL BOARD
35 State House Station
Augusta, ME 04333
Tel. (207)624-8627, Fax (207)624-8636
Maine Relay 711 (TTY)

NEW NAME OF FACILITY:
ADDRESS OF FACILITY:
CITY STATE ZIP COUNTY
PHONE # ( ) FEDERAL I.D. NUMBER:

FORMER NAME OF FACILITY:	LICENSE#
CITY STATE ZIP COUNTY	

NAME OF OWNER OF DISPENSING STATION EQUIPMENT:
ADDRESS OF OWNER
CITY STATE ZIP COUNTY
PHONE # ( ) FAX # ( ) LICENSE #

NAME OF PROPANE SUPPLIER (BRANCH SERVING DISPENSER): _____
ADDRESS OF SUPPLIER: _____

EFFECTIVE DATE: _____

By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional & Occupational Regulation will rely upon this information for issuance of my license and that this information is truthful and factual. I also understand that sanctions may be imposed including denial, fines, suspension or revocation of my license if this information is found to be false.

SIGNATURE OF OWNER: **DATE:**

CHANGE OF LIMITED OPERATOR APPLICATION

STATE OF MAINE
DEPARTMENT OF PROFESSIONAL & FINANCIAL REGULATION
OFFICE OF PROFESSIONAL & OCCUPATIONAL REGULATION
MAINE FUEL BOARD
35 State House Station, Augusta, ME 04333
Tel. (207)624-8627, Fax (207)624-8636
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PLEASE NOTE: IT IS THE RESPONSIBILITY OF THE DISPENSING STATION OWNER TO ENSURE THAT LIMITED OPERATORS ARE REGISTERED WITHIN 14 DAYS OF HIRE IN ORDER TO DISPENSE PROPANE. OPERATOR TRAINING SHALL OCCUR ON AN ANNUAL BASIS.

LIMITED OPERATOR INFORMATION (please print)			
FULL LEGAL NAME *FIRST* *MIDDLE INITIAL* *LAST*			
DATE OF BIRTH *mm / dd / yyyy*		SOCIAL SECURITY NUMBER - -	
MAILING ADDRESS			
CITY	STATE	ZIP	COUNTY
PHONE # ( )	FAX # ( )		DATE OF HIRE
By my signature, I hereby certify that the information provided on this application is true and accurate to the best of my knowledge and belief. By submitting this application, I affirm that the Office of Professional and Occupational Regulation will rely upon this information and that this information is truthful and factual.			
SIGNATURE		**DATE**	

DISPENSING STATION INFORMATION (please print)			
NAME OF FACILITY			
MAILING ADDRESS OF FACILITY			
CITY	STATE	ZIP	COUNTY
DISPENSING STATION LICENSE #			

IF YOU ARE CURRENTLY LICENSED AS A PLANT OPERATOR AND/OR DELIVERY TECHNICIAN YOU DO NOT NEED TO COMPLETE THE FOLLOWING AFFIDAVIT.

I am currently licensed as a: ❒Plant Operator ❒Delivery Technician — License #: _____

AFFIDAVIT

I hereby certify that _____ has
(Name of Limited Operator)
been properly trained as the Limited Operator in accordance with 32 MRS §18142(2)(B).

Date:_____ _____
Signature of Limited Operator

_____
Facility Name Typed or Printed

Date:_____ _____
Signature of Training Representative

_____
Training Representative Name Typed or Printed

_____
Company Name of Owner of the Filling Equipment