Decommissioning Notification
Stage II Vapor Recovery

MUST BE SUBMITTED AT LEAST SEVEN (7) DAYS PRIOR TO DECOMMISSIONING

A. IDENTIFICATION

Station Site Name		Station Owner Name:	
Site Street Address:		Mailing Address:	
City/Town:		City/Town:	
State:	Zip Code:	State:	Zip Code:
Telephone Number:		Telephone Number:	

B. Facility ID Number: _____

C. Throughput per year: _____ million (MM) gallons per year

D. Type of System: Aspirated ☐ Balance ☐ Vaccuum-Assist ☐

Tank top accessible without excavation: YES ☐ NO ☐

Decommissioning Company Name (please print):	Decommissioning Date:
Technician Signature: (Note: Signer is verifying that system will be decommissioned following the PEI 300-09 - Chapter 14 standard.)	Date:
Station Owner Representative Name (please print):	
Station Owner Representative Signature:	Date:

Certification, checklist and test report must be submitted 30 business days after decommissioning.
Forms are available on RI DEM's website at http://www.dem.ri.gov/pubs/forms.htm#air

Send Completed Form To:

State of Rhode Island
Department of Environmental Management
Office of Air Resources
235 Promenade Street, Room 230
Providence, RI 02908
Phone: 401-222-2808
Fax: 401-222-2017