



MISSOURI DEPARTMENT OF HEALTH  
STATE PUBLIC HEALTH LABORATORY  
BREATH ALCOHOL PROGRAM

**APPLICATION FOR TYPE III PERMIT FOR OPERATION OF BREATH ALCOHOL ANALYZERS**

THIS APPLICATION IS FOR <input type="checkbox"/> NEW PERMIT <input type="checkbox"/> RENEWAL		PERMIT NUMBER	EXP. DATE	DPS CERT. NUMBER AND DATE
NAME			TITLE	AGE
DEPARTMENT OR TROOP				TELEPHONE (       )
BUSINESS ADDRESS (STREET, TOWN, ZIP)				

**LIST ALL ORIGINAL TRAINING COURSES FOR OPERATION OF BREATH ANALYZERS.**  
(Also, please be sure an X is placed beside ALL breath analyzer(s) for which you are requesting a permit.)

DATES OF COURSE	LOCATION OF COURSE	COURSE LENGTH (CLOCK HRS.)	NAME & MODEL OF BREATH ANALYZER	PLACE AN X BESIDE INSTRUMENTS FOR WHICH YOU REQUEST A PERMIT	NAME OF INSTRUCTOR

**IF THIS IS AN APPLICATION FOR A NEW PERMIT, INCLUDE A COPY OF APPLICANT'S EXAM**

**IF THIS IS A RENEWAL APPLICATION, AND/OR YOU ARE ADDING A NEW INSTRUMENT TO YOUR CURRENT PERMIT, READ THE FOLLOWING INSTRUCTIONS AND PROVIDE THE FOLLOWING ADDITIONAL INFORMATION:**

**When adding a new instrument, you receive a new two (2) year permit. Therefore, normal renewal procedures apply for the instruments on your current permit that you wish to transfer to the new permit. Disregarding those renewal procedures will result in a new permit for the new instrument only.**

To renew a Type III permit, the applicant shall have performed at least ten (10) tests on drinking subjects in the past year on each instrument for which renewal is requested. If this condition is not met or the permit has expired for more than thirty (30) days, the applicant shall complete a two (2) hour refresher training course under the supervision of an individual with a valid Type II permit. The refresher training course shall include the performance of five (5) subject tests for each breath analyzer for which renewal is requested. Copies of the completed operational checklists and printouts for the subject tests shall accompany the renewal application.

**NUMBER OF DWI SUBJECT TESTS PERFORMED DURING THE PAST YEAR: (Indicate instrument name and number)**

1) INSTRUMENT NAME	SUBJECTS	2) INSTRUMENT NAME	SUBJECTS	3) INSTRUMENT NAME	SUBJECTS

SIGNATURE OF APPLICANT	DATE OF APPLICATION
▶	

**TO BE COMPLETED BY TYPE II**

Recommendation of Supervisor Type II:  
Name of Type II (Please Print) \_\_\_\_\_

I certify that \_\_\_\_\_ (NAME OF APPLICANT) is qualified to operate the breath analyzer devices as requested in this application.

SIGNATURE OF TYPE II PERMITTEE	PERMIT NUMBER	BUSINESS PHONE
▶		

COMPLETE APPLICATION AND RETURN TO: DIRECTOR OF LABORATORIES  
MISSOURI DEPARTMENT OF HEALTH  
307 W. McCARTY  
JEFFERSON CITY, MO 65101