



STATE OF MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 BUREAU OF ENVIRONMENTAL HEALTH SERVICES  
 ONSITE WASTEWATER TREATMENT PROGRAM  
**Training Provider Certification Application**

**INSTRUCTIONS:**

1. The following items must be submitted for each training course, seminar, or conference 60 days prior to first scheduled session.

- Completed Training Provider Certification Application.
- Timed Agenda.
- Course Overview.
- Copy of Certificate for Attendees.
- Description of Visual Aides, Copy of Manual (if applicable) and Handouts.
- Submit a Curriculum Vitae and Contact Information for Each Instructor.
- Copy of Written Exam (if applicable).

An incomplete application will delay review and approval.

2. Mail complete application(s) and document(s) for review to:

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
 ONSITE WASTEWATER TREATMENT PROGRAM  
 PO BOX 570  
 JEFFERSON CITY, MO 65102-057  
 FAX: (573) 526-7377

Please Type or Print Legibly		
<b>SECTION A: AGENCY/ORGANIZATION TRAINING PROVIDER INFORMATION</b>		
NAME OF AGENCY/ORGANIZATION		
MAILING ADDRESS (STREET, CITY, STATE, ZIP)	AGENCY/ORGANIZATION PHONE#	AGENCY/ORGANIZATION FAX #
AGENCY/ORGANIZATION CONTACT NAME(S)		
	PHONE #	EMAIL ADDRESS
1.		
2.		
SECTION B: INDIVIDUAL TRAINING PROVIDER INFORMATION (Instructor/presenter should have education and experience to be able to demonstrate adequate familiarity and understanding of the subject matter on a test and/or by presenting a sample presentation for DHSS review.)		
NAME		
MAILING ADDRESS (STREET, CITY, STATE, ZIP)		
PHONE #	FAX #	EMAIL ADDRESS
<b>SECTION C: TRAINING COURSE, SEMINAR OR CONFERENCE</b>		
TITLE		
INTENDED AUDIENCE FOR COURSE, SEMINAR OR CONFERENCE		
<input type="checkbox"/> Installers <input type="checkbox"/> Percolation Testers <input type="checkbox"/> Soil Evaluators <input type="checkbox"/> Inspectors <input type="checkbox"/> Other(s) _____		
<b>TYPE OF APPLICATION</b>		
<input type="checkbox"/> <b>New Application</b> <input type="checkbox"/> <b>Renewal Application</b> <input type="checkbox"/> Check this box if you prefer <b>NOT</b> to have your training course(s) published on the CEU webpage.		
<b>SECTION D: TRAINING MANAGER(S) OR PRINCIPAL INSTRUCTOR(S)</b>		
NAME:		
MAILING ADDRESS (STREET, CITY, STATE, ZIP)		
PHONE #	FAX#	E-MAIL ADDRESS
BY SIGNING BELOW, I HEREBY CERTIFY THAT THE INFORMATION INCLUDED IN THIS APPLICATION, AND ANY SUPPLEMENTAL INFORMATION ATTACHED TO IT, IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND UNDERSTANDING.		
SIGNATURE (TRAINING MANAGER OR PRINCIPAL INSTRUCTOR)		DATE

**\*\*Please notify DHSS of locations, dates of scheduled courses, any changes in instructors or agenda and mail or fax copy of sign-in sheet(s) of attendees within two (2) weeks of training.\*\***