



For Office Use Only:
Notification #: _____

MOLD REMEDIATION NOTIFICATION FORM

DO NOT WRITE IN THIS BOX- FOR DEPARTMENT USE ONLY
Date Received: ___/___/___ Source: ___Fax ___E-mail ___Mail ___Walk-in

TYPE OF NOTIFICATION: (Select one and fill in the requested information)

ORIGINAL: The DSHS Central Office was notified by: ___ Fax ___ E-mail ___ Hand Delivery ___ Mail
Date sent: ___/___/___ Time sent: _____ ___a.m. ___p.m.

AMENDMENT No. ___ OR CANCELLATION

Amendment/Cancellation Notification Required Information:

Was the Environmental Health Notifications Group (EHNG) notified by phone between 8:00 a.m. and 5:00 p.m. Central Time of any project date changes or cancellation prior to the original start and/or original stop date? ___Yes ___No.

If yes, provide the name of the person you spoke with: _____

Was the original amended notification faxed/e-mailed/overnight-mailed within 24 hours of the phone call? ___Yes ___No.
Date: ___/___/___ Time: _____ ___a.m. ___p.m.

Additional Required Notice for Date Changes Less Than 5 Days from Original Start/Stop Date:

Was the appropriate Regional Office notified by e-mail/phone between 8:00 a.m. and 5:00 p.m. Central Time of any project date changes or cancellation prior to the original start and/or original stop date? ___Yes ___No

If yes, provide the name of the person you spoke with: _____

Date: ___/___/___ Time: _____ ___a.m. ___p.m.

Was a copy of the amended notification faxed/e-mailed/overnight-mailed to the appropriate Regional Office within 24 hours of the phone call? ___Yes ___No.

Give a description of the reason for this amendment or cancellation: _____

EMERGENCY

Was emergency request made to the Regional Office or (EHNG) by phone? ___Yes ___No

If yes, provide the DSHS reference number: _____ and name of the person you spoke with: _____
Date: ___/___/___ Time: _____ ___a.m. ___p.m.

Describe the reason for emergency remediation: _____

(x) Below if Amended

AMENDMENTS: You must complete the entire form and mark the appropriate check box(es) along the left-hand side of form below to indicate amended information.

FACILITY INFORMATION

1. Facility Location/Description of Area

Facility/Residence Name: _____

Physical Address: _____

County: _____ City: _____ Zip: _____

Facility Contact Person: _____ Phone #: () _____

Description of area/room number: _____

Area of mold to be remediated: _____ Number of floors: _____

2. Type of Facility (Select one)

___ Owner-occupied Residential Dwelling Unit ___ Other

WORK SCHEDULE/DESCRIPTION OF WORK TO BE CONDUCTED

1. Scheduled dates of mold remediation:

Start date: ___/___/___ and Stop date: ___/___/___

Work days: ___ Mon. ___ Tues. ___ Wed. ___ Thurs. ___ Fri. ___ Sat. ___ Sun.

Working hours: _____ ___a.m. ___p.m. to _____ ___a.m. ___p.m.

2. Description of work to be conducted

Description of mold remediation to be conducted: _____

(X)

Below If Amended

PROJECT INFORMATION

1. Facility Owner

- Owner of Residence/Facility (Last, First, Middle Initial): _____
- Address of Owner, if different from facility: _____
- City: _____ State: _____ Zip: _____

2. Licensed Mold Remediation Contractor

- Contractor License #: _____ Phone #: () _____
- Name of Mold Remediation Contractor: _____
- Address: _____
- City: _____ State: _____ Zip: _____

3. Licensed Mold Remediation Company

- Company Affiliation (if any): _____
- Company License #: _____ Phone #: () _____

4. Licensed Mold Assessment Consultant

- Consultant License #: _____
- Name of Consultant: _____
- Date of mold assessment protocol: ___/___/___

5. Mold Analysis Laboratory

- Laboratory License #: _____
- Name of Mold Analysis Laboratory: _____

BILLING INFORMATION

Check only one box below to indicate who should be billed and fill in the requested information:

- Remediation Company: _____ License #: _____
- Remediation Contractor: _____ License #: _____
- Alternate mailing address for invoice (if different):
Attn: _____
Address: _____
City: _____ State: _____ Zip: _____

CERTIFICATION STATEMENT

I hereby declare that I have examined this notification and, to the best of my knowledge and belief, all information provided is complete, true, and correct. I affirm that I am the licensed contractor and that I am responsible for the fee associated with this notification. I also understand that I am responsible for notification to the department.

(Signature of Licensed Contractor)

Date: ___/___/___

(Printed Name & Title)

Employer Company Name: _____ Phone #: () _____
E-mail Address: _____

IMPORTANT INFORMATION

NOTIFICATION TIMELINESS REQUIREMENT: A mold remediation contractor/company must submit this notification form to the department when a mold remediation project has mold contamination that affects a total surface area of 25 contiguous square feet or more. The department must receive this form at least five working days (not calendar days) before the actual date that mold remediation begins (preparation work not included), unless an emergency exists per section 295.325(e) of the Texas Mold Assessment and Remediation Rules.

CALL FOR ASSISTANCE: (512) 834-6770 ext. 2172 or (888) 778-9440 (Toll- free in Texas) ext. 2172

E-MAIL FORM TO: mold_notifications@dshs.state.tx.us

FAX FORM TO: (512) 834-4524

MAIL FORM TO: ENVIRONMENTAL HEALTH NOTIFICATIONS GROUP
TEXAS DEPARTMENT OF STATE HEALTH SERVICES
PO BOX 143538
AUSTIN, TX 78714-3538