Medical Gas Permit Application

City of Durham
17160 SW Upper Boones Ferry Road, Durham, OR 97224
Phone 503-639-6851 Fax 503-598-8595
Assistant.cityofdurham@comcast.net
www.durham-oregon.us
Call for Inspections 503-691-3040

OFFICE USE ONLY

Date received: _____ Permit # _____

Date Issued: _____ By:____ Receipt: _____

PROJECT INFORMATION

Project name: _____

Job address: _____ Bldg no: _____ Suite no: _____

City/county: _____

Tax Map Numbers: _____ Lot: _____ Block: _____ Subdivision: _____

Description and location of work on premises: _____

_____

Estimated Date of Completion/Inspection: _____

PLUMBING CONTRACTOR

Business Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ E-mail: _____

CCB No: _____ Plumbing Business License No: _____ Med. Gas Cert. No: _____

CONTACT PERSON

Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ E-mail: _____

OWNER

Name: _____

Address: _____
Street City State Zip

Phone: _____ Fax: _____ E-mail: _____

VALUATION

Project value: _____ Formula: value/1000 x 6.9 + 37.45 = permit fee (min. fee = $105.00)

Permit Fee from formula above: _____

Plan Review = 65% of permit fee: _____

Fire/Life Safety = 40% of permit fee: _____

State Surcharge = 12% of permit fee: _____

Total Permit Fee: _____

MEDICAL GAS SYSTEMS:

Number of Outlets:_____

Types of Gases: _____ _____

_____ _____

_____ _____

_____ _____

System Level: (circle one) **1.** **2.** **3.** **4.**

Number of cylinders: _____

MEDICAL VACUUM SYSTEMS:

Number of Outlets: _____

Number of Vacuum Pumps: _____

MEDICAL/DENTAL AIR SYSTEMS

Number of Outlets: _____

Number of Compressors: _____

WASTE ANESTHETIC GAS DISPOSAL SYSTEM

Yes_____ No _____

SYSTEM VERIFICATION BY 3RD PARTY REQUIRED

Yes _____ No _____

THIRD PARTY DOCUMENTATION REQUIRED

Yes _____ No _____

Signature of Applicant: _____

Permit Approved By: _____