



Medical Gas Permit Application

City of Durham

17160 SW Upper Boones Ferry Road, Durham, OR 97224

Phone 503-639-6851

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: $\text{value}/1000 \times 6.9 + 37.45 = \text{permit fee}$ (min. fee = \$132.50)

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: _____