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# WEST VIRGINIA STATE BOARD OF SANITARIANS

P.O. Box 927  
Charleston, West Virginia 25323

## Out-of-State Applicants for Registration with the West Virginia State Board of Sanitarians Applying for Reciprocity:

Must sign the following prior to consideration of application for registration with the Board.

I hereby certify that I am knowledgeable of the requirements of the Sanitarian Registration Act and the Clarification Policy concerning section 20-4-4.1.6 and 7. Specifically that:

4.1.6. Completes food and onsite wastewater training and any additional training as determined by the Board.

4.1.7. Completes other action as required by the Board.

Clarification: This section refers to the training offered by the WVDHHR/BPH/OEHS Public Health Sanitation Division at the Annual Sanitarian Training School. This includes the food program and on-site sewage program as well as other courses determined necessary by the Board. These courses must be completed at the **next available** Sanitarian Training School after registration has been approved by the Board and active employment in a sanitarian classification in West Virginia. An extension for completion may be given by the Board for extenuating circumstances. The applicant will be considered a full registrant with the Board and able to perform all duties in the appropriate sanitarian classification during the allowable time period for completion of the courses. Failure to complete these training courses or other actions in 4.1.6 as required by the Board will cause the registrant to be non-compliant with the Sanitarian Registration Act and will be grounds for their registration to be revoked.

I hereby acknowledge that I am subject to the above requirements and the full policy clarification and agree to them if my application for Registration is approved and I am issued a Registration by the West Virginia State Board of Sanitarians.

I hereby swear that the above statements are true Applicant Signature \_\_\_\_\_

If already employed in West Virginia in a sanitarian classification, the employer must agree to these terms by signing.

Supervisor/Health Officer Signature \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

The above named persons personally appeared before me this \_\_\_\_ day of 20\_\_ and after being duly sworn , said that the above statements were true in every respect.

Notary Public \_\_\_\_\_

My commission expires (seal required)\_\_\_\_\_.