

# MISSISSIPPI ASBESTOS DEMOLITION/RENOVATION NOTIFICATION FORM

Mail notification to: **MDEQ Asbestos Section, 515 E. Amite Street, Jackson, MS 39201**

Operator Project #	Postmark	Date Received (MDEQ use only)	Notification # (MDEQ use only)	
I. Type of Notification (O=Original R=Revised C=Canceled A= Annual) <b>O</b>				
II. TYPE OF OPERATION (D=Demo O= Ordered Demo R=Renovation E=Emer. Renovation) <b>R</b>				
III. FACILITY DESCRIPTION (Include building name, number and floor or room number)				
Bldg. Name: <b>UMC Clinical Science - L 407</b>				
Address <b>2500 North State St</b>				
City: <b>Jackson</b>	State: <b>MS</b>	Zip: <b>39216</b>		
Site Location:		Tel: <b>601-984-1000</b>		
Building Size <b>100,000 +/-</b>	# of Floors: <b>6</b>	Age in Years: <b>50 +/-</b>		
Present Use: <b>Hospital</b>	Prior Use: <b>Hospital</b>			
IV. FACILITY INFORMATION (Identify owner, removal contractor, and other operator)				
OWNER NAME: <b>University Medical Center</b>				
Address: <b>2500 North State St</b>				
City: <b>Jackson</b>	State: <b>MS</b>	Zip: <b>39216</b>		
Contact: <b>Virgil Lamkin</b>		Tel: <b>601-984-1412</b>		
REMOVAL CONTRACTOR <b>Eagle Construction</b>				
Address: <b>1450 Old Brandon Rd</b>				
City: <b>Flowood</b>	State: <b>MS</b>	Zip: <b>39232</b>		
Contact: <b>Chuck Womack</b>		Tel: <b>601-940-5411</b>		
OTHER OPERATOR:				
Address:				
City:	State:	Zip:		
Contact:				
V. IS ASBESTOS PRESENT? (Yes/No) <b>Yes</b>				
VI. PROCEDURE, INCLUDING ANALYTICAL METHOD, IF APPROPRIATE, USED TO DETECT THE PRESENCE OF ASBESTOS MATERIAL (Include inspector name and date of inspection):				
<b>Assumed</b>	<b>Chuck Womack</b>	<b>10/1/2020</b>		
VII. APPROXIMATE AMOUNT OF ASBESTOS INCLUDING:	RACM To Be Removed	Nonfriable Asbestos Material Not To Be Removed		Indicate Unit of Measurement Below
<ol style="list-style-type: none"> <li>1. Regulated ACM to be Removed</li> <li>2. Category I ACM Not Removed</li> <li>3. Category II ACM Not Removed</li> </ol>		Category I	Category II	UNIT
Pipes				Ln Ft:      Ln M:
Surface Area	400 sq ft FT/M			Sq Ft: <b>X</b> Sq M:
Vol RACM Off Facility Component				Cu Ft:      Cu M:
VIII. SCHEDULED DATES ASBESTOS REMOVAL (MM/DD/YY) Start: <b>12/11/2020</b>		Complete: <b>12/13/2020</b>		
IX. SCHEDULED DATES DEMO/RENOVATION (MM/DD/YY) Start: <b>12/11/2020</b>		Complete: <b>12/30/2020</b>		

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NOV 30 REC'D

Dept. of Environmental Quality

X. DESCRIPTION OF PLANNED DEMOLITION OR RENOVATION WORK, AND METHOD(S) TO BE USED:

**Removal of asbestos containing materials with hand tools**

XI. DESCRIPTION OF WORK PRACTICES AND ENGINEERING CONTROLS TO BE USED TO PREVENT EMISSIONS OF ASBESTOS AT THE DEMOLITION OR RENOVATION SITE:

Stop work and notify competent person

XII. WASTE TRANSPORTER #1

Name: ADS, Inc

Address: P. O. Box 1296

City: Clinton

State: MS

Zip: 39060-1296

Contact Person: Mark Parkman

Tel: 601-925-0507

WASTE TRANSPORTER #2

Name: Eagle Construction

Address: 1450 Old Brandon Rd

City: Flowood

State: MS

Zip: 39232

Contact Person:

Tel:

XIII. WASTE DISPOSAL SITE

Name: Little Dixie Landfill

Address: 1716 North County Line Rd

City: Ridgeland

State: MS

Zip: 39157

Tel: 601-982-9488

XIV. IF DEMOLITION ORDERED BY A GOVERNMENT AGENCY, PLEASE IDENTIFY THE AGENCY BELOW:

Name:

Title:

Authority:

Date of Order (MM/DD/YY):

Date Ordered to Begin (MM/DD/YY):

XV. FOR EMERGENCY RENOVATIONS:

Date and Hour of Emergency (MM/DD/YY):

Description of the sudden unexpected event:


Explanation of how the event caused unsafe conditions or would cause equipment damage or an unreasonable financial burden:

XVI. DESCRIPTION OF PROCEDURES TO BE FOLLOWED IN THE EVENT THAT UNEXPECTED ASBESTOS IS FOUND OR PREVIOUSLY NONFRIABLE ASBESTOS MATERIAL BECOMES CRUMBLLED, PULVERIZED, OR REDUCED TO POWDER:

**Keep wet & notify owner**

XVII. I CERTIFY THAT AN INDIVIDUAL TRAINED IN THE PROVISIONS OF THIS REGULATION (40 CFR PART 61, SUBPART M) WILL BE ONSITE DURING THE DEMOLITION OR RENOVATION, AND EVIDENCE THAT THE REQUIRED TRAINING HAS BEEN ACCOMPLISHED BY THIS PERSON WILL BE AVAILABLE FOR INSPECTION DURING NORMAL BUSINESS HOURS.

Chuck Womack  
Type or Print Name

  
(Signature of Owner/Operator)

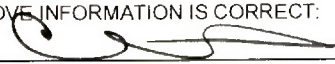
11/30/2020

(Date)

XVIII. I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT:

Chuck Womack

Type or Print Name

  
(Signature of Owner/Operator)

11/30/2020

(Date)