FINANCIAL ASSURANCE MECHANISM REVIEW REQUEST

REQUESTOR:				
	NAME	**ORGANIZATION**	**EMAIL**	**PHONE NUMBER**

DATE OF REQUEST:		**DATE NEEDED BY:** (min. 30 days from request)		**APPLICABLE REVIEW CLOCK CLOSING DATE:**	

FACILITY INFORMATION

TYPE OF FACILITY:	
PERMIT ACTION:	
CLOSURE/POSTCLOSURE PLAN:	
CORRECTIVE ACTION PLAN:	

IF THE PLAN IS FOR LESS THAN THE ENTIRE SITE, PLEASE PROVIDE AN EXPLANATION IN COMMENTS.

FACILITY NAME:		**SWIS NO:**		**COUNTY:**	

FACILITY ADDRESS:					
OPERATOR NAME:					
OWNER NAME:					
FACILITY CONTACT:		**PHONE NUMBER:**		**EMAIL:**	

CLOSURE AND P0STCLOSURE MAINTENANCE COST ESTIMATES

CLOSURE COST ESTIMATE:	$	**ANNUAL POSTCLOSURE COST ESTIMATE:**	$
DATE OF PLAN OR REVISION TO PLAN:			
ANTICIPATED CLOSURE DATE:		**CLOSURE CERTIFICATION DATE:**	

KNOWN OR REASONABLY FORESEEABLE RELEASE COST ESTIMATE

TYPE OF CORRECTIVE ACTION:		**COST ESTIMATE:**	$
DATE OF PLAN OR REVISION TO PLAN:			

COMMENTS: