

Parsippany - Troy Hills



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HEALTH DEPARTMENT
Carlo DiLizia
Health Officer

APPLICATION FOR DEMOLITION PERMIT

NAME OF APPLICANT _____

ADDRESS _____

TELEPHONE _____

ADDRESS AND LOCATION OF DEMOLITION:

BLOCK _____ LOT _____

NAME OF LICENSED EXTERMINATOR _____

ADDRESS _____

NOTE: Submit letter from licensed exterminator. Letter must include date of initial treatment and date of re-inspection indicating no activity observed. Dates must be at least 10 days apart.

NAME OF WASTE DISPOSAL FACILITY _____

ADDRESS _____

STATE _____

NAME AND ADDRESS OF CARTER, IF WASTE NOT TRANSPORTED BY APPLICANT.

SIGNATURE OF APPLICANT

APPROVED BY: _____ DATE: _____

Health Department Demolition Permit expires _____ (This is 90 days from Exterminators Date of no activity).