

**APPLICATION TO MODIFY A SOLID WASTE  
DISPOSAL FACILITY PERMIT**

Date: \_\_\_\_\_ County: \_\_\_\_\_

Send to:

Solid Waste Permitting Unit  
Waste Management Division  
Dept. of Environmental Quality  
707 N. Robinson (PO Box 1677)  
Oklahoma City, OK 73101-1677

<b>FOR DEQ USE</b>	
DEQ Log No.	_____
No. Copies	_____
Date Received:	_____

\_\_\_\_\_ proposes to modify the permit of  
*(Applicant's Name)*  
the \_\_\_\_\_, located at \_\_\_\_\_  
*(Facility Name)* *(Exact legal description:*  
\_\_\_\_\_  
*metes & bounds, platted lot, or land survey. Append extra sheets if necessary)*

in \_\_\_\_\_ County, Oklahoma. We hereby make application for a modification of existing permit number \_\_\_\_\_ as required by the **Oklahoma Solid Waste Management Act** and the Rules pursuant thereto.

Remarks & brief description of proposed modification:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant or Authorized Agent:

Preparing Engineer:

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Typed Name*

\_\_\_\_\_  
*Typed Name*

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Date signed: \_\_\_\_\_

Date signed: \_\_\_\_\_

Phone: \_\_\_\_\_

Phone: \_\_\_\_\_

Facility Address (if any): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

<b>DEQ USE ONLY</b>	
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**VERIFICATION<sup>1</sup>**

STATE OF OKLAHOMA )  
 )  
COUNTY OF \_\_\_\_\_ ) ss

\_\_\_\_\_, of lawful age, being first duly sworn, upon oath state that I have read the foregoing APPLICATION TO MODIFY A SOLID WASTE DISPOSAL FACILITY PERMIT, that I am familiar with the matters set forth therein, and that the same are true to the best of my information and belief.

\_\_\_\_\_  
Applicant

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_,  
by \_\_\_\_\_ (Applicant or legal representative).

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

My commission expires:  
  
\_\_\_\_\_

\_\_\_\_\_  
<sup>1</sup> This Verification is required for a Tier III modification application.