



Town of Kearny

Department of Public Health • Walter J. Nicol Health Center
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DEMOLITION APPLICATION

Site Address: _____ Block: _____ Lot: _____ Date: _____

Pest Control Operator's Name: _____ State License #: _____

Trade Name of Licensed Pest Control Operator: _____

Address: _____

Phone: _____ Email: _____ Fax: _____

Property Owner's Name: _____ Signature: _____

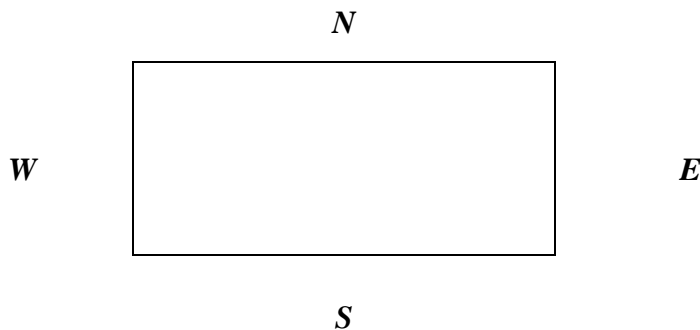
Address: _____

Phone: _____ Email: _____ Fax: _____

Initial Date of Treatment: _____ Type of Bait(s): _____

PEST CONTROL SERVICE REPORTS MUST BE ATTACHED WITH THIS APPLICATION.

Location of Baits:



OFFICE USE ONLY

Name of Health Inspector(s): _____ Date of Inspection: _____

Location of Pest Activity (if none, then state "None"): _____

Re-Inspection: Yes No If yes, then property owner must provide receipt of second extermination.

Severity of Vermin Activity (if none, then write "None"): _____ Final Inspection Date: _____

Health Department Approval: Yes No Signature: _____ Date: _____

DEMOLITION APPROVAL EXPIRES TWO WEEKS FROM APPROVAL DATE. APPLICATION MUST BE SUBMITTED TO CONSTRUCTION CODE ENFORCEMENT FOR FINAL APPROVAL.