REPORTING YEAR:
$200.00 FILING FEE PER FACILITY

STATE OF HAWAII
CHEMICAL INVENTORY FORM (TIER II)

ATTACHMENT 5-A-1
Refer to Attachment 5 for instructions on completing this form

FACILITY IDENTIFICATION	OWNER/ OPERATOR IDENTIFICATION
NAME:	NAME: TITLE:
HEPCRA FACILITY IDENTIFICATION NUMBER:	
STREET ADDRESS:	PHONE: ALTERNATE PHONE:
CITY: STATE: HI ZIP:	MAILING ADDRESS:
LATITUDE: LONGITUDE: COUNTRY: US	CITY: STATE: ZIP:
Is this facility manned? ☐ MANNED ☐ UNMANNED Maximum Number of Occupants:	E-MAIL:
RMP: ☐ YES ☐ NO EPCRA: ☐ YES ☐ NO	**EMERGENCY CONTACTS** *(Please provide a primary and a secondary emergency contact)*
SIC CODE:	NAME: TITLE:
DUN & BRAD NUMBER: NAICS:	PHONE: 24-HR PHONE:
State I. D. Number	EMAIL:
MAILING ADDRESS: *(If different from facility address)*	NAME: TITLE:
CITY: STATE: ZIP:	PHONE: 24-HR PHONE:
COUNTY:	EMAIL:

Chemical Description	Physical and Health Hazards	Inventory	Storage Type			Locations (Non-Confidential)
			Container	Pressure	Temp	
☐ Check if all of the information for this chemical is Identical to the information submitted last year	☐ Fire	Max Daily Amount (code)				
CAS ☐ Trade secret ☐ Confidential	☐ Sudden release of pressure	Avg. Daily Amount (code)				
Chemical Name:	☐ Reactivity	No. of Days On-site (days)				
Check all that apply ☐ Pure ☐ Mix ☐ Solid ☐ Liquid ☐ Gas ☐ EHS	☐ Immediate (acute)	☐ Below Reporting Threshold				
	☐ Delayed (chronic)					

Certification (Read and sign after completing all sections)

I certify under penalty of law that I have personally examined and am familiar with the information submitted and that based on my inquiry of those individuals responsible for obtaining this information, I believe that the submitted information is true, accurate and complete.

Name and official title of owner/operator OR operator's authorized representative | **Signature** | **Date**

Optional Attachments

☐ I have attached a site plan
☐ I have attached a list
☐ I have attached a description of dikes and other safeguard measures

FOR DOH HEER USE ONLY

DATE PAYMENT RECEIVED: REVIEWED BY: DATE:
CHECK NO:
DATE HCIF RECEIVED: FACILITY ID: DOCUMENT NUMBER: