



AFFIDAVIT OF CONTINUITY MEDICAL GAS INSTALLATION

I, _____ certify that _____
(Print Name of Owner, Authorized Contractor representative, or Union representative) (Print Name of Medical Gas Installer)

has performed brazing in Washington as an employee of _____

(Print Name of Company) (Print UBI or License Number)

Brazing is required 4 times within your renewal cycle, at approximately six month intervals. Dates are required.

_____ (Month)	_____ (Year)	_____ (Month)	_____ (Year)
_____ (Month)	_____ (Year)	_____ (Month)	_____ (Year)

(Signature of Owner, Authorized Contractor representative, or Union representative)

Contractor / Union Representative signature MUST be notarized

Subscribed and Sworn to me this _____ day of _____

X _____

Notary Public in and for the State of _____ residing in _____

My commission expires _____

AFFIDAVIT OF REVIEW

I, _____ certify that I have reviewed the current Medical Gas code
(Signature of Medical Gas Endorsement holder)
adopted by the Washington State Building Code Council.