



FP-296

The Commonwealth of Massachusetts
Executive Office of Public Safety and Security
Department of Fire Services

P.O. Box 1025 ~ State Road

Stow, Massachusetts 01775

(978) 567 - 3100 Fax: (978) 567 - 3199



BLASTING REGULATORY REVIEW FORM

(To be completed by complainant or property owner and returned to the head of the fire department within 30 days of the alleged incident; please print clearly)

Date of Incident: Time of Incident: Location of Incident: (City / Town)

Type of Structure: Address of Structure: (residential / commercial / other) (Street)

Property Owner's Name: Phone Number:

Property Owner's Address: Street Address City State Zip

Complainant's Name If Different: Phone Number:

Complainant's Address If Different: Street Address City State Zip

Was a Pre-Blast Survey done on this property prior to the start of blasting? YES NO

DESCRIPTION OF ITEM OR AREA OF ALLEGED DAMAGE

Three horizontal lines for describing the item or area of alleged damage.

Note to Property Owner: when you have signed and dated this form, submit it to the local fire department for review and completion. Do not submit the Blasting Damage Complaint Form directly to the Office of the State Fire Marshal.

CERTIFICATION OF DAMAGE - PLEASE READ AND SIGN

I declare under the penalty of perjury that the statements and information provided herein are true as of the date of this complaint. I am aware that there are significant penalties for submitting false information including possible fines, civil penalties and imprisonment.

Signature of Property Owner: Date Signed:

Date received by the head of the fire department

(To be completed by Fire Department)  
**BLASTING COMPANY AND FIRE DEPARTMENT INFORMATION**

Name of Fire Department: \_\_\_\_\_ Address of Blast: \_\_\_\_\_

Name of Blasting Company Use and Handling [Permit to Blast] Issued to: \_\_\_\_\_

Blasting Company Phone Number: \_\_\_\_\_ Explosives User's Certificate Number: \_\_\_\_\_

Name of Pre-Blast Survey Company: \_\_\_\_\_ Survey Company Phone Number: \_\_\_\_\_

Name of Liability Insurance Carrier: \_\_\_\_\_ Insurance Carrier Phone Number: \_\_\_\_\_

Blaster's Name: \_\_\_\_\_ Certificate of Competency Number: \_\_\_\_\_

Blaster's Work Phone Number: \_\_\_\_\_

Blaster's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REPORT OF FIRE DEPARTMENT INQUIRY AND VIOLATION(S) FOUND**

Were the Blasting Logs reviewed as a result of this complaint?: YES NO

Were violation(s) found as a result of the review of this complaint?: YES NO

If yes, has a Notice of Violation been issued by your department? (If yes, attach copy): YES NO

Signature of Fire Department Officer: \_\_\_\_\_ Date: \_\_\_\_\_

*After review of this complaint, please send copies of this form, blasting log(s), seismograph record(s) and Notice(s) of Violation to the Office of the State Fire Marshal. Incomplete complaints will be returned to the department.*

----- State Fire Marshal Use Only -----

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Logs Attached: Yes No Violations: Yes No

Comments/Notes: \_\_\_\_\_