

**FORM 2**

Biosolids Land Application Local Monitoring Expenses

**MULTIPLE OWNERS PAYMENT ASSIGNMENT**

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An application for reimbursement may be submitted to the Virginia Department of Environmental Quality by several Local Governments that employ the same local monitor entity if this form is included as part of the application. For reimbursement of expenses incurred by a local monitor serving multiple Local Governments, each Local Government (claimant) must sign and submit a separate Form 1, Reimbursement Invoice attesting to the performance of monitoring activity by the local monitor named below and sign and notarize this Multiple Owners Payment Assignment form.

Local Monitor Name: \_\_\_\_\_

Local Monitor Mailing Address: \_\_\_\_\_

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

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

Local Monitoring Activity - Beginning Date: \_\_\_\_\_ Ending Date: \_\_\_\_\_

County where monitoring activity occurred	Responsible Local Official (printed name)

**MONITORING ACTIVITIES CERTIFICATION**

I certify that the monitoring activities for which reimbursement is sought have been performed in accordance with the provisions of the VPA Permit Regulation (9VAC25-32-10 et seq.) and the Fees for Permits and Certificates regulation (9VAC25-20-10 et seq.) in the counties listed above.”

\_\_\_\_\_  
Local Monitor Signature

\_\_\_\_\_  
Date

**FORM 2**

**Biosolids Land Application Local Monitoring Expenses  
MULTIPLE OWNERS PAYMENT ASSIGNMENT FORM**

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Claimant Invoice Number: _____	<b>DEQ Use Only</b> MOP Assignment Number: _____
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This form is for use by claimants who wish to assign their reimbursement payment to another party. A copy of the notarized original of this form must be submitted with reimbursement invoices for which the claimant wishes to assign the payment to another party.

**Party Assigning Payment:**

County (Claimant): \_\_\_\_\_

Name of Local Government Official: \_\_\_\_\_

Total Payment Assigned in this Application: \$ \_\_\_\_\_

**Party to Receive Payment:**

County (Assignee): \_\_\_\_\_

Name: \_\_\_\_\_

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

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

Contact Name of Assignee: \_\_\_\_\_ Phone: \_\_\_\_\_

By signing below, I:

1. Assign the invoice reimbursement payment for the above-referenced claim and any reconsideration of that claim to the Assignee designated above.
2. Warrant and represent that I am the claimant, or in claims in which the claimant is not an individual, that I have the authority to assign this payment on behalf of the claimant.
3. Agree that the assignment by this form applies only to the reimbursement claim with which it is submitted and any reconsideration of that claim.
4. Agree that use of this form does not transfer my liability for the submitted invoice.
5. Agree that any check issued as a result of this reimbursement claim will be issued only to the name of the party designated as the assignee on this form.
6. Agree that if the check is issued to the claimant rather than the party designated as assignee on this Assignment Request Form, I bear the responsibility for transferring the payment to the assignee.

\_\_\_\_\_  
Claimant Signature

\_\_\_\_\_  
Date

**THIS STATEMENT MUST BE NOTARIZED**

State of \_\_\_\_\_ }  
 } ss:  
 City/County of \_\_\_\_\_ }

Subscribed and sworn to before me by \_\_\_\_\_ on this \_\_\_\_\_ day of \_\_\_\_\_.

/s/ \_\_\_\_\_ My commission expires \_\_\_\_\_