

Sewage Certification

Read the instruction carefully. Answer all questions as completely as possible.

Date of request ___/___/___

Inspection Fee: \$ _____ Re-inspection Fee: \$ _____ Date Fee Paid: ___/___/___

Address of Lot: _____ City _____, Ohio _____

Requested By: _____ Agency: _____ Phone: _____

Owner(s) Name: _____ Address: _____, Ohio _____

Phone: (____) _____ - _____ Lot Size: _____ Parcel I.D. Number: _____

Year Dwelling was built: _____ Number of Bedrooms in Dwelling: _____ Basement: YES NO

Type of Drinking Water Supply: _____ If Private Water System, Year Installed _____

Date Septic Tank was Last Pumped: _____ Risers on Tank? YES / NO

(Automatic re-inspection plus re-inspection fee if no risers are on tank at time of initial inspection.)

Has the residence been vacant for more than 30 consecutive days within the past six months? YES / NO

If residence was or is vacant, give amount of time residence was or has been vacant. _____

I, as owner or agent for the above property, believe to the best of my knowledge, that the information provided is true. I authorize representatives of the Ross County Health District to conduct investigations of the property to ascertain the operating condition, maintenance needs, history, and compliance of the water system and sewage treatment system as governed by the Ohio Private Water Rules Chapter. 3701-28 OAC, , the Ross County Health District Sanitary regulation and those applicable portions of the State Interim Sewage Treatment Rules.

Receipt number _____

Signature of Owner or Agent Phone Date

Sanitarian Use Only

Permit on File YES NO Permit #: _____ **HSTS System:** approved/ disapproved

Reason for disapproval: _____

Date of Final Inspection: ___/___/___ Installer: _____

Date of Certification Inspection: ___/___/___ **Weather Conditions:** _____

Building Sewer: 4" Schedule 40 or equivalent: YES / NO **Clean Out** YES / NO

Sewage system: Pretreatment: _____ **Total Gallons:** _____

Secondary Treatment: Leach field / Leach Bed / Surface Filter / Subsurface Filter/

Up Flow Filter / ETA / Mound /

Type, Size, and Design: _____

Tertiary Treatment: YES / NO Type, size, and Design: _____

Auxiliary Component(s): (i.e. D-box, lift station, Timer, Alarm) _____

Dye Test performed: YES / NO Color used: _____ Dye Observed: YES / NO
If dye is observed, give location: _____

Discharging System: YES / NO Discharge Point: _____

NPDES Permit: YES / NO (OHK000001 General Permit) for discharging STS's after 01/01/2007

Service Contract: YES / NO / NA Name of Service Provider: _____

Distances from: House _____, Water Lines _____, Water System, _____, Property
Line _____, Roadway, _____, Driveway _____ Easements _____,
Neighboring Water Systems, _____ Other Structures _____,

Sanitarian's Comments or Recommendations at time of Inspection:

Corrections to be made for compliance with Chapter 3701-29 O.A.C. _____

Drawing (not drawn to scale)

The Ross County Health District does not warrant or guarantee past or future operational performance of this system. This certification report is valid of 45 days.

Sanitarian Signature: _____