Ross County Health District, Environmental Public Health Services
475 Western Avenue, Suite 3A, Chillicothe, Ohio 45601
Telephone: 740-775-1158 Fax: 740-779-9615 Website: www.rosscountyhealth.com

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:
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Corrections to be made for compliance with Chapter 3701-29 O.A.C.______________________________
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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: ____