St. Joseph County Department of Health

"Promoting physical and mental health and facilitating the prevention of disease, injury, and disability for all St. Joseph County residents"

SEPTIC SYSTEM OPERATING PERMIT APPLICATION

Commercial: ____ Residential: _____ Septic Permit Application Number: _____ Date: _____

System Owner:

Name: _____

Address: _____City: _____ State: _____Zip: _____

Telephone #: _____ Work #: _____ Fax #:_____

Contact Information for Responsible Person:

Name: _____

Address: _____City: _____ State: _____Zip: _____

Telephone #: _____ Work #: _____ Fax #:_____

Emergency phone number: _____ Alternate: _____

Facility Served by the Septic System:

Name: _____

Address: _____

Telephone: _____

List the total authorized capacity of the system: _____ gallons per day.

Operator/ Maintenance Contractor:

Name of licensed contractor: _____

Address: _____City: _____ State: _____Zip: _____

Telephone #: _____ Work #: _____ Fax #:_____

A copy of an executed monitoring and maintenance agreement with the signatures of owner and contractor is required.

____ Attached ____ To be submitted (Operating Permit will not be granted until this has been submitted and approved)

Certifications:

I hereby certify that I am the owner of the septic system described above or the authorized representative of the owner and that the above statements are true and accurate. I certify that I have the authority to and I hereby grant permission and consent for the Department of Health to enter onto the property containing the cluster system without prior notice to conduct inspections and collect soil and water data as necessary to assure compliance with all applicable laws, rules, ordinances, etc. pertaining to the installation and function of the septic system. I certify that if there are any changes to the information described above, I will submit a revised application within seven working days. I certify that I will report any malfunctions of the septic system to the Department of Health within two working days.

_____ _____

Signature of Applicant Date

_____

Print Company/Entity Name (If any)

For Department of Health Use Only
Application #: _____
Transaction #: _____
Transaction Date: _____