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Sub./Lot Review: _____ Fee Paid: _____
 Complaint: _____ Receipt #: _____
 Other: _____ Received By: _____

HAMILTON COUNTY GENERAL HEALTH DISTRICT

APPLICATION TO CONSTRUCT OR REPLACE A SEWAGE TREATMENT SYSTEM

APPLICANT TO FILL OUT SHADED SECTIONS ONLY.

NEW REPLACEMENT (Plumbing Permit Required If All Wastewater Is Not Directed To Septic System)

Address of Construction Site: _____ **Political Subdivision:** _____
 Owner(s) Name: _____ Tax Parcel #: _____ Lot Size: _____ acre(s)
 Phone Number: _____
 Mailing Address: _____
 System To Serve: Single Family Public (Water Supplier _____)
 Duplex Private
 Triplex Well Cistern Hauled Water
 Other: _____
 Plumbing Under Basement Ejector Pit Hung Sewer
 Number of Bedrooms: _____ Number of People in Structure: _____ Monthly Water Usage: _____
 Watersoftner Garbage Disposal Whirlpool Style Tub High Capacity Shower
 Other Large Water Usage Fixtures: _____

Soil Type / Characteristics: _____
 STS Daily Design Flow: _____ STS Average Design Flow: _____ Soil Absorption Rate: _____ Linear Loading Rate: _____

Sewage Treatment System Type: _____
Primary Treatment Tank: Building Sewer _____
 Controls _____
 Trash Trap _____ Gallons _____ Compartment(s) _____
 Septic Tank _____ Gallons _____ Compartment(s) _____
 Dosing Tank _____ Gallons _____ Compartment(s) _____
 Dosing Septic Tank _____ Gallons _____ Compartment(s) _____
 Dosing Basin _____ Depth _____ Diameter or _____ x _____
 Effluent Filter _____
 Screen Vault Filter _____
 Other _____
 Pump _____
 Siphon _____
 Gravity _____
Comments: _____

Secondary Treatment Unit: _____
 Intermittent Sand Filter _____ ft x _____ ft = _____ ft² _____
 Recirculating Gravel Filter _____ ft x _____ ft = _____ ft² _____
 Recirculating Sand Filter _____ ft x _____ ft = _____ ft² _____
 Recirculating Textile Filter _____ Manufacturer _____ Unit(s) _____
 Peat Biofilter _____ Manufacturer _____ Unit(s) _____
 Aerobic Treatment Unit _____ Manufacturer _____ GPD _____
 Other _____
 Filter Following Treatment Unit _____
 Dosing Basin _____ Depth _____ Diameter or _____ x _____
 Soil Absorption (See Below) _____
 Pump _____
 Siphon _____
 Gravity _____
Comments: _____

Soil Absorption Component: _____
 Gravel Pad _____ ft x _____ ft = _____ ft² _____ Depth _____
 Leaching Trenches _____ ft x _____ ft = _____ ft² _____ Depth _____ Total Ln. Ft. _____
 Leach Bed _____ ft x _____ ft = _____ ft² _____ Depth _____
 At-Grade _____ ft x _____ ft = _____ ft² _____ Sand Thickness _____
 Modified Mound _____ ft x _____ ft = _____ ft² _____ Sand Thickness _____
 Wisconsin Mound _____ ft x _____ ft = _____ ft² _____ Sand Thickness _____
 Other _____
 Gravity Distribution _____
 Drip Distribution _____
 LPP Distribution _____
Comments: _____

Drainage Enhancement: _____
 Gradient Drain _____ Depth _____
 Interceptor Drain _____ Depth _____
 Diversion Swale _____
 Other _____
 Pump _____
Disinfection Device: _____
 Chlorinator _____
 Chlorine Contact Chamber _____
 De-Chlorinator _____
 UV _____
 Other _____
Comments: _____

Remarks: _____

ODH System Type: Pretreat SDC
 Below Grade Pretreat SDC & Drip
 At or Above Grade Drip Only
 NPDES Discharge Spray/Surface App.
 None of the Above
 Refer to Site Plan _____ For Additional Details And Install System Per HCGHD Manual.

By my signature below I certify that I have read, I understand, and I agree to comply with the conditions set forth on the reverse hereof.
 Owner's/Owner's Agent Signature: _____ Date: _____

Field Inspection By: _____ Date: _____ Approved By: _____ Date: _____
 This Application Expires One Year From The Approved By Date. Replacement Systems Must Be Installed Within 120 Days of Approval Date.

Address of Construction Site:

Political Subdivision:

File #:

OWNER MUST READ AND INDICATE AGREEMENT BY SIGNING ON THE FRONT:

I understand that any approval granted on the basis of false or inaccurate information is automatically revoked. Approval is similarly revoked for my failure to comply with any requirements or conditions herein or any additional requirements of the Hamilton County Board of Health or the State of Ohio.

I agree to have a Registered Installer obtain a Sewage Treatment System (STS) Installation Permit prior to starting any work on a STS installation. I also understand that a repair or alteration of a STS requires a permit from the Hamilton County Board of Health. I understand that **THIS APPLICATION EXPIRES ONE YEAR FROM THE APPROVED DATE**, and no installation permit will be issued after that date. If the application expires, I must re-apply for a new permit and pay another application fee.

I understand that if the system has electrical components, a permit and inspection approval must be obtained from the Local Building Inspection Department prior to issuance of the final STS installation approval and operational permit.

I understand that the STS and all components contained within it require routine maintenance. Therefore, I agree to operate, maintain, and service the system and its components in accordance with any and all rules or requirements of the Hamilton County Board of Health and the State of Ohio. Depending on the STS type, a operation, monitoring, maintenance and service contract with a Registered Service Provider may be required before final system installation approval is granted and the STS is placed into operation.

All STS require an Operational Permit from the Hamilton County General Health District. I understand that Health District Personnel will monitor this STS as often as necessary to obtain information and to verify that the system is functioning in a satisfactory manner so that an Operation Permit may be issued. I understand that actions of Health District inspectors, engaged in the evaluation and determination of measures required for the siting, design, installation, and monitoring of this STS, shall in no way be taken as guarantee that the system will function in a satisfactory manner for any given period of time, or that the Hamilton County General Health District or any of its agents or employees assume any liability for damages, consequential or direct, which are caused, or which may be caused by a malfunction of the STS.

In the event that the STS fails to function in a satisfactory manner, as determined by the Hamilton County General Health District, I will take immediate action to correct any malfunctions, ensuring that the system functions in a satisfactory manner.

I WILL NOT OCCUPY A NEW DWELLING OR STRUCTURE OR ALLOW OCCUPANCY UNTIL ALL FINAL TESTS AND INSPECTIONS HAVE BEEN CONDUCTED AND APPROVED ON INTERIOR AND EXTERIOR PLUMBING AND THE SEWAGE TREATMENT SYSTEM.

I hereby certify that the proposed work is authorized by the owner of record. If I am signing this application as the owner's authorized agent, we have agreed to conform to all applicable laws of the State of Ohio and the regulations of the Hamilton County General Health District.