HAMILTON COUNTY
PUBLIC HEALTH
PREVENT. PROMOTE. PROTECT.

Timothy I. Ingram
Health Commissioner

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hamiltoncountyhealth.org

STS Alteration Application

Fee Paid _____ Date _____

Receipt # _____ Received by _____

Alt # _____

☐ Residential ☐ Commercial

_____

STS Location | No. of Bedrooms | Township/Village/City

Job description: _____

Applicant/Agent

_____
Name

_____
Mailing address Phone

_____
City State Zip

Owner
(If different from above)

_____
Name

_____
Mailing address Phone

_____
City State Zip

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.

_____ _____
Applicant's Signature Date

Sanitarian Remarks: _____

_____

_____

_____ _____
Sanitarian's Signature Date

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) Alteration Permit prior to starting any work on the existing STS. I understand that THIS APPLICATION EXPIRES ONE YEAR FROM THE APPROVED DATE, and no alteration 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 alteration 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, an operation, monitoring, maintenance and service contract with a Registered Service Provider may be required before final system alteration approval is granted.

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 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.