DISTRICT HEALTH DEPARTMENT NO. 4
EXISTING SYSTEM EVALUATION REPORT

Issued at: [ ] Alpena (989) 356-4507 [ ] Atlanta (989) 785-4428 [ ] Cheboygan 231) 627-8850 [ ] Rogers City (989) 734-4723

APPLICATION:

Home Owners Name: _____
Dwelling Address: _____
Township: _____
City or Township: T _____ R _____ Section # _____
Subdivision: _____ Lot # _____
Parcel ID#: _____

Direction to Dwelling or Map Attached From Nearest Intersection _____

MAIL REPORTS TO:
[ ] Owner's Representative: _____
Address: _____
City: _____ Zip: _____
Phone: _____

Dwelling Occupied: [ ] Yes [ ] No

Contact Person:
Name _____
Phone Number _____
Total Number of Bedrooms _____

Previous Owners or Builders Names: _____
Approximate Date of House Construction _____, Septic Construction _____, Well Construction _____
Purpose: Change of building use ____, Addition to existing structure ___, Replacement structure ___
Description of Project: _____

ACKNOWLEDGEMENT:

The information provided is based on skilled observation by trained Environmental Sanitarians, and is indicative of the conditions present at the time of the survey. Records relating to this survey are available upon request.

Since many factors contribute to the function of a sewage disposal system, any change in circumstances may affect its continued function.

I ACKNOWLEDGE AND AGREE that District Health Department No. 4, its divisions, board, officers, agents, and employees are not responsible for any loss allegedly due to any act or omission in connections with the performance of the survey requested herein:

Date: _____ Signature of Owner or Designated Representative: _____

[ ] Owner [ ] Builder [ ] Installer [ ] Other _____

A site plan must be completed and attached.

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FOR HEALTH DEPARTMENT USE

SURVEY:

ON-SITE SEWAGE DISPOSAL SYSTEM

	Yes	No	See Comments
Record of permit available	____	____	____
Known sewage disposal problems in area:	____	____	____
Evidence of malfunction:	____	____	____
Meets minimum requirements of sewage disposal regulations:	____	____	____

Possible Replacement System:
[ ] Standard [ ] Elevated [ ] Other

Comments: _____

Date: _____ Survey conducted by: _____

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Office Use Only: Date Rec'd _____ **Fee** _____ **Check #** _____ **Cash** _____ **OR #** _____

Original - Local Health Department Yellow - Owner or Designated Representative
Pink - Building Department

DHD NO. 4 EH-111 - R-06/05 - MODEL PRINTING SERVICE, INC.

Web