

OFFICE USE ONLY

GRANT COUNTY HEALTH DISTRICT (509) 766-7960

**WATER SYSTEM AND/OR
ON-SITE SEWAGE SYSTEM
CERTIFICATION REPORT**

Applicant: _____

Property's Tax Parcel Number: _____

GROUP B PUBLIC WATER SYSTEM:

Name of System: _____ I.D. #: _____ Compliance Status: _____

Number of Approved Connections: _____ Number of Existing Connections: _____

_____ **INDIVIDUAL / TWO PARTY WELL** _____ **FARM EXEMPT WELL** # of Connections _____ (4 max)

Bacteriological Sample:

Nitrate Sample:

Date Evaluated: ____/____/____

Date Evaluated: ____/____/____

Water Sample Drawn: ____/____/____

Water Sample Drawn: ____/____/____

Results: _____ Satisfactory (____)

Results: _____ Below 5.0

_____ Unsatisfactory (____)

_____ Target 5.0↑

_____ 10.0 MCL↑

Obvious biological issues w/in 100 feet? Y ____ N ____

Obvious chemical issues within 100 feet? Y ____ N ____

Any obvious problems with well cap? Y ____ N ____

Is there a screened well vent? Y ____ N ____

If in a pit, is it drained? Y ____ N ____ NA ____

If atmospheric storage is used, is it reasonably protected? Y ____ N ____ NA ____

Comments: _____

SEWAGE DISPOSAL SYSTEM:

Date Evaluated: _____ House Occupied? _____ Yes _____ No

_____ System records reveal original installation complied with State and County Regulation; currently there is no obvious system malfunction.

_____ System records indicate system was installed without required permit and/or inspections. No obvious system malfunction.

_____ No system records available; no obvious system malfunction.

_____ System malfunction: _____

Comments: _____

The above statements reflect observed conditions as they existed, and/or laboratory results of samples collected, on the day the evaluation was performed. Observations recorded and statements made are presented here by request and make absolutely no claim, either expressed or implied, for future success or failure of the system evaluated.

Evaluation performed by: _____ **Date:** _____