GRANT COUNTY HEALTH DISTRICT
1038 W. Ivy Moses Lake, WA 98837 (509) 766-7960

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

Please check desired evaluation:

□ Certification – Septic System & Water (With Bacteria Sample)……$187.00**
□ Certification – Septic System & Water (With Bacteria & Nitrate Sample)..…..…….$213.00**
□ Certification/Evaluation – Water System Only……$157.00**
□ Bacteria Sample only……..……..$ 81.00**
□ Bacteria & Nitrate sample Only……..……..…..….$107.00** (Each Re-test Bacteria sample).....$ 51.00**
Plus fees of chosen lab

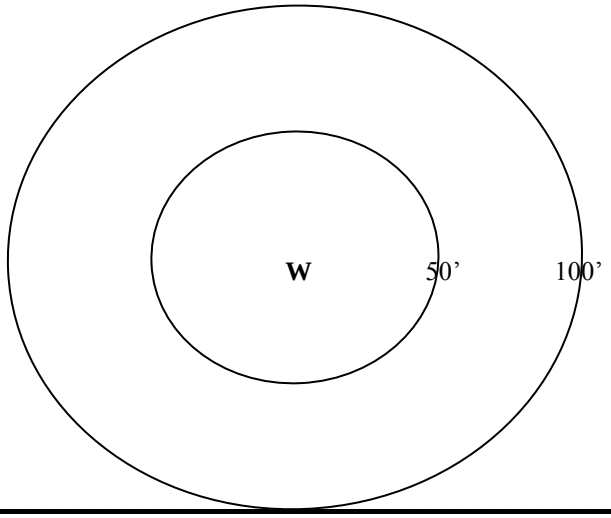
Please fill out application in full. Incomplete applications will be returned.

Applicant Name _____ Daytime Phone # _____
System Address_____
City, State, Zip _____
Tax Parcel No. _____ Sec _____ Twn _____ Rng _____
Subdivision _____ Lot _____ Blk _____ Div _____
1) Person to contact for dwelling entry _____ Phone # _____
2) Name of original owner or builder _____Year Built _____
Number of Bedrooms in Home_____
3) Septic tank pumped within last 5 years? □ Yes □ No □ Unknown If yes, when? _____
(If the septic system is more than 5 years old, pumping is required and a copy of receipt must be provided to the GCHD).
4) Has the well/distribution system been disinfected? □ Yes □ No □ Unknown If yes, when?_____

FOR WATER SYSTEM EVALUATIONS

Use the schematic to the right that shows a 100 foot and 50 foot radius around the well. If any of the following are located within 100 feet, identify the locations with the following numbers:

ST) Septic tank
DF) Drainfield
C) Chemicals
SW) Surface Water
B) Buildings
LS) Livestock areas
OC) Other contamination sources
(please specify): _____



FIRMS OR PERSONS TO WHOM REPORT IS TO BE MAILED (if applicable)**:**

Seller Name_____
Address _____
City, State, Zip _____
Daytime Phone # _____

Purchaser Name _____
Address_____
City, State, Zip _____
Daytime Phone # _____

Name of Lender _____
Attn: _____
Address _____
City, State, Zip_____
Phone # _____

Other _____
Attn: _____
Address _____
City, State, Zip _____
Phone # _____

**Thirty dollars of each requested refund will be retained by the Grant County Health District for administrative expenses.*

**DO NOT WRITE BELOW THIS LINE **

Date _____ Rec # _____ Amt Paid _____ Initial_____
Evaluated By_____ Date_____ Date reports sent _____ Initial _____