

# Grant County Health District

1038 W. Ivy, Moses Lake, WA 98837 (509) 766-7960 www.granthealth.org

## Group B Water System Application

Water System Name: \_\_\_\_\_

Contact Name \_\_\_\_\_ Phone Number \_\_\_\_\_

\*\*\*\*\*Required Information\*\*\*\*\*Check all items submitted with initial application\*\*\*\*\*

**Located within or less than 1/4 mile from an existing Water System's Future Service Area?** \_\_ Yes \_\_ No

If yes, include letter allowing creation of a new system.

### Water Quality/Quantity Data

- Include a certified water lab report for Bacteriological (Coliform)
- Include a certified water lab report for IOC Analysis

### Other Documents -as part of a completed Group B Workbook.

- Include a completed WFI
- Include a copy of the Well Site Inspection
- Include a copy of the Well Log
- Water Rights (if applicable)
- Declaration Covenant
- Restrictive Covenant (if applicable)
- Pump Test
- Copy of "Notice to Future Property Owners" (recorded with Grant County Auditor)
- Copy of recorded Water Users Agreement or appropriate CCR's (if more than 1-property served)
- Include a System Layout Map showing the well, water lines, sewer components, property lines, buildings, and all potential sources of contamination located within 600 feet of the well.
- Totalizing Source Meter Specifications
- Pressure Relief Valve Specifications
- Separate Irrigation Contract (If applicable)
- Satellite Management Agency Agreement
- Site Protection Map
- Hydraulic Analysis
- Financial Viability Worksheet

**After the Water System Application Design is approved, the Water System can be constructed. After the system is completed, a Construction Completion Report will need to be submitted before the system approval can be finalized and a Public Water System ID number assigned.**

*My signature certifies that this information is true to the best of my knowledge. I grant permission to the Health District to make reviews required by the permit process. I understand that this application will become public record. I understand that any decision made by the Health District may be appealed, provided the appeal is made in writing and delivered to the Health District within 30 days of the decision. I also understand that supplying incorrect and/or incomplete information may result in permit revocation and/or additional costs may be incurred. If a refund is requested, a processing fee will be charged based upon services rendered.*

**APPLICANTS SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Date Received: \_\_\_\_/\_\_\_\_/\_\_\_\_ Amount Received \_\_\_\_\_ Receipt No. \_\_\_\_\_ By \_\_\_\_\_