

**STATE OF FLORIDA
DEPARTMENT OF HEALTH
APPLICATION FOR AEROBIC TREATMENT UNIT
MAINTENANCE SERVICE PERMIT**

Authority: Chapter 381, F.S.
Chapter 64E-6, F.A.C.

Permit/ Application Number: _____
Date received: ____/____/____
Fee Paid: _____
Receipt Number: _____

Application is hereby made to the DOH _____ County Health Department, requesting the issuance of an Aerobic Treatment Unit Maintenance Service Permit for the following business:

Business Name: _____ Phone: _____

Business Location: _____ City: _____ State: _____ Zip: _____

Business Mailing Address (If different from above): _____

Owner/Agent (Circle One): _____

Owner/Agent Mailing Address: _____ City: _____ State: _____ Zip: _____

Description of Geographic Area Serviced from this Location: _____

List the Brands of Aerobic Treatment Units you are Authorized to Service (Provide a letter from each manufacturer of an aerobic treatment unit you will service stating that you are authorized to provide service to that type of unit and will be provided with training, operation and maintenance manuals, service equipment, and spare mechanical parts in order to provide necessary warranty and maintenance service to their brand of unit).

Aerobic Unit	Manufacturer	Manufacturer's Address
_____	_____	_____
_____	_____	_____
_____	_____	_____

Number of aerobic treatment units currently under contract _____; Number of full-time maintenance service personnel _____, Does your company currently retain a Class D wastewater treatment plant operator to provide service to systems treating more than 1500 gallons per day? Yes _____ No _____ If yes, provide a copy of the operator's certification. Is your company licensed as a plumbing service or do you possess a septic tank contractor registration or certificate of registration from DOH.
Plumbing Contractor: Yes _____ No _____ Qualifying Contractor: _____ License Number: _____
Registered Septic Tank Contractor: Yes _____ No _____ Qualifying Contractor: _____ Registration Number: _____
Authorized Septic Tank Service: Yes _____ No _____ Certificate of Authorization Number: _____

List service and repair equipment available at your facility:

Equipment	Quantity	Equipment	Quantity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I am familiar with the requirements of Chapter 64E-6, F.A.C. and understand that I must be in possession of a current maintenance service permit in order to operate an aerobic treatment unit maintenance service. I further understand that a maintenance service permit may be revoked for failure to comply with the requirements of chapter 64E-6, F.A.C.

Signature of Owner or Agent

_____/_____/_____
Date

County Health Department Recommendation: Approve _____ Disapprove _____

If disapproved, explain: _____

Recommendation by: _____ CHD Date ____/____/____