

**STATE OF FLORIDA
DEPARTMENT OF HEALTH
APPLICATION FOR ONSITE SEWAGE TREATMENT AND DISPOSAL SYSTEM OPERATING PERMIT**

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

Application/Permit Number _____

New: _____ Amended: _____ Renewal: _____

Aerobic: _____ Commercial: _____ Industrial/Manufacturing: _____

GENERAL INFORMATION

Property Owner _____

Work Telephone _____ Home phone: _____

Address of Owner: _____ City: _____ State _____ Zip _____

Owner's Agent: _____

Agent's Address: _____ City: _____ State _____ Zip _____

Agent's Phone: _____ Property Street Address: _____

City: _____ State _____ Zip _____

Section: _____ Township: _____ Range: _____ Parcel: _____ Lot: _____ Block: _____ Subdivision: _____ Unit: _____

EXISTING SYSTEM INFORMATION

Please complete those items shown below which are applicable to the existing permitted onsite sewage disposal system serving the above referenced property: Onsite Sewage Treatment and Disposal System Construction Permit Number (if known): _____

Septic Tank(s)/Aerobic Unit _____ gallons Grease Trap(s) _____ gallons Dosing Tank _____ gallons

Drainfield size is _____ square feet installed in a: standard subsurface _____ filled _____ mound system _____

The drainfield layout is in trenches _____ absorption bed _____ other _____ (describe) _____

Onsite Well? Yes _____ No _____ System Setback to Wells _____ ft. Lot Size _____ Square Feet

Estimated sewage flow into system _____ Gallons/Day Based on _____

Number of businesses or dwellings (circle one) which are being served by this onsite sewage disposal system _____

Additional Comments: _____

COMMERCIAL/INDUSTRIAL/MANUFACTURING FACILITY

Please attach a business survey form for each business which is or will be served by the onsite sewage disposal system. Briefly describe the type of activities that will be supported by the onsite sewage system serving this property. _____

What is the zoning designation for the property? _____ Give a description of the zoning and examples of approved businesses in this type of zoning: _____

AEROBIC TREATMENT UNIT

Date of aerobic system installation approval: _____ / _____ / _____ Is the aerobic treatment unit still under the manufacturer's initial two year warranty? Yes _____ No _____ Aerobic Unit Manufacturer: _____

Type of Aerobic Unit: _____ Class I: _____ Class II: _____ Above 1500 Gallon Capacity: _____

Construction/Installation Permit Number: _____ Are multiple aerobic units used on the site: Yes _____ No _____

Is there an active service agreement on the aerobic treatment unit? Yes _____ No _____ Please Attach a Copy of the Agreement

If yes, when does the service agreement expire? _____ / _____ / _____

Who is the authorized service company providing maintenance to your unit?

Company Name _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

I hereby certify that the above information is accurate and a reflection of the actual conditions existing on the above referenced property. I understand that any change of occupancy or tenancy at the above location will require me to file an amendment to this operating permit.

Applicant's signature: _____ Date _____ / _____ / _____

Application Status:

Disapproved: _____ Date _____ / _____ / _____ Reason: _____

By: _____ Title: _____ CHD

Approved: _____ Date _____ / _____ / _____

By: _____ Title: _____ CHD

BUSINESS SURVEY
 AN ATTACHMENT TO DH 4081
 ASSESSMENT OF WASTE HANDLING AND BUSINESS ACTIVITIES

New: _____ Application/Permit Number _____
 Renewal: _____
 Change of Tenancy/Amendment: _____

Please provide the following information regarding your business facilities and the activities which will take place on site.

Business Name _____ Occupational License #: _____
 Business Owner's Name _____
 Business Mailing Address _____ Telephone _____
 City _____ State _____ Zip _____
 Street Address of Business _____ Unit Number _____
 City _____ State _____ Zip _____

How many employees will use this facility _____ Hours of operation _____
 What type and number of sanitary facilities will be available at this location: Anticipated flow: _____ gpd Based on _____
 Toilets _____ Urinals _____ Hand Washing Sinks _____ Utility Sinks _____
 Showers _____ Floor Drains _____ Equipment Drains(Describe) _____
 2-Compartment Sinks _____ 3-Compartment Sinks _____
 Laundry Facilities _____ Garbage Grinder/Disposal _____
 Commercial Dish Machines (heat sanitizing) _____ (chemical sanitizing) _____
 Can Washing Facilities _____ Other(Describe) _____

Completely describe the activities which will take place at your business location (i.e. types of waste generated, volume of raw materials handled, amount of wastes generated, equipment used in the process):

List any chemical compounds routinely used in your business: Attach Material Safety Data Sheets for Compounds Used or Stored

Name	Gal or lbs./Month	Amt. on hand	Storage Method	Disposal Method	SIC Code
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list licensed waste haulers removing wastes from your site.

Company Name	Type of Waste Removed
_____	_____
_____	_____
_____	_____

Describe how emergencies, such as spills, will be handled at this site:

As the business owner, I understand that information contained in this application serves as a basis for determining the suitability of the onsite sewage disposal system to serve the business described above. Information contained herein is an accurate reflection of the activities which will be allowed on this site. I also agree to perform any testing as may be required by this permit, and collection & analysis of samples will be done at my own expense by a state certified laboratory. I also agree to notify the county health department of the change in any material fact used to determine the issuance of this permit.

Business Owner or Agent's Signature: _____ Date _____
 Property Owner or Agent's Signature: _____ Date _____

TO BE COMPLETED BY COUNTY HEALTH DEPARTMENT:

Will monitoring be required: Yes ___ No ___ Sample location _____ Compounds to be examined: _____
 Is DER/ County Haz Waste review required: Yes ___ No ___ Monitoring Frequency _____
 Survey disapproved _____ Date: ___/___/___ Reason _____

Survey approved: _____ By: _____ Title _____ CHD Date: ___/___/___