**EXISTING SEWAGE AND/OR PRIVATE WATER SYSTEM EVALUATION**

**FORM PROVIDED BY:** SUMMIT COUNTY PUBLIC HEALTH  
1867 WEST MARKET STREET, AKRON, OHIO 44313  
PHONE (330) 926-5600 FAX (330) 923-6436 WWW.SCPHOH.ORG

**GENERAL INFORMATION**

**INSPECTION CONDUCTED BY:**  
___ REGISTERED SERVICE PROVIDER  
(REGISTRATION NUMBER____________________)  
___ PRIVATE WATER SYSTEM CONTRACTOR  
(ODH REGISTRATION NUMBER____________________)

**COMPANY NAME:** ___________________________________________________________________

**INSPECTOR NAME:** ____________________________________   **PHONE NUMBER:** ____________________

**TEST REQUESTED:** ___ SEWAGE (SEE PAGES 3,4)    ___ WATER (SEE PAGES 5,6)

**DATA REQUESTED:** ___ LEAD   ___ NITRATE   (BACTERIA IS REQUIRED)

**WILL SEWAGE/WATER BE EVALUATED BY ANOTHER COMPANY:**  ___ YES   ___ NO

**PROPERTY ADDRESS:** ___________________________________________________________________

**CITY:** ______________________   **ZIP:** _______________   **PARCEL I.D.** ________________

**POLITICAL SUBDIVISION:** ______________________   **DATE OF INSPECTION:** ____________

**BUYER’S NAME:** _______________________________________________________________________

**BUYER’S CURRENT MAILING ADDRESS:** _______________________________________________________________________

**CITY:** _______________   **STATE:** _______   **ZIP:** _______   **BUYER’S PHONE:** _______________

**BUYER’S REALTOR:** _____________________________   **REALTOR PHONE:** ___________________

**OWNER’S NAME:** _______________________________________________________________________

**OWNER’S CURRENT MAILING ADDRESS:** _______________________________________________________________________

**CITY:** _______________   **STATE:** _______   **ZIP:** _______   **OWNER’S PHONE:** _______________

**OWNER’S REALTOR:** _____________________________   **REALTOR PHONE:** ___________________

**YEAR OF HOME CONSTRUCTION (IF KNOWN)_______   **NUMBER OF BEDROOMS_______

**PERSON RESPONSIBLE FOR PROVIDING ACCESS TO PROPERTY:** ______________________________

**PHONE:** __________________

**PROPERTY HAS:**  
___ HOME SEWAGE TREATMENT SYSTEM   ___ SEWER  
___ PRIVATE WATER   ___ PUBLIC WATER

**THE OPINION GIVEN IS RENDERED WITHOUT KNOWLEDGE OF SOME OF THE INDIVIDUAL PARTS OF THE SYSTEM(S) BEING EVALUATED AND ONLY APPLIES TO THE DATE AND TIME THE OPINION IS MADE. THEREFORE, THIS OPINION DOES NOT GUARANTEE THE FUTURE PERFORMANCE OF THE SYSTEM(S) BEING EVALUATED. THE WATER TESTS DO NOT ASSESS THE CHEMICAL QUALITY OF THE WATER, OTHER THAN WHAT IS LISTED.**

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Page 1  
3/2015
PROPERTY ADDRESS: ________________________________

PROPERTY DIAGRAM: RECOMMEND TO INCLUDE NORTH ARROW, LOT DIMENSIONS, HOUSE, PRIVATE WATER SYSTEM, SEWAGE TREATMENT SYSTEM, AND DISTANCES. DISTANCES SHOWN ARE ESTIMATED USING THE BEST AVAILABLE MEASUREMENTS.

INSPECTOR’S SIGNATURE: ________________________________ DATE: ______________________

REGISTERED CONTRACTOR’S SIGNATURE (if different from inspector): ________________________________ DATE: ______________________
PROPERTY ADDRESS: _____________________________________________________________

SEWER APPEARS TO BE AVAILABLE: Y/N  HSTS RECORDS AVAILABLE: Y/N ___ATTACHED

NUMBER AND SIZE OF SEPTIC TANKS: ____________________________________________
RISERS ON: ___ INLET ___ OUTLET (2ND TANK: ___ INLET ___ OUTLET)
BAFFLES FUNCTIONING: Y/N ___ UNKNOWN  OUTLET “T” FUNCTIONING: Y/N ___ UNKNOWN

AEROBIC TANK: Y/N MANUFACTURER: __________ SERVICE CONTRACT: Y / N ___ATTACHED
(IF SYSTEM IS EQUIPED WITH AEROBIC TANK THE SYSTEM MUST RUN CONTINUOUSLY)

MONTH/YEAR TANK(S) LAST PUMPED: __________________________
INFORMATION SOURCE: ___ HEALTH DEPARTMENT ___ OTHER (IF OTHER, ATTACH COPY)
WATER LEVEL IN THE TANK(S) AND OR AEROBIC TREATMENT DEVICE BEFORE ANY WATER USE:
WATER LEVEL IN THE TANK(S) AND OR AEROBIC TREATMENT DEVICE AFTER HYDRAULIC LOADING:
VOLUME OF WATER USED DURING HYDRAULIC LOADING: _____ GALLONS

SYSTEM WAS DYE TESTED: Y/N (IF YES, LOCATION DYE WAS PLACED : ________________)

SPLIT SYSTEM: Y / N  SPLITTER BOX EXPOSED: Y / N  FILTER: Y / N ___ UNKNOWN  SIZE: __________
SOIL TREATMENT: ___ TILE FIELD ___ LEACH WELL ___ DRY BED/LEACH AREA ___ EVAPOTRANSPIRATION ___ MOUND ___ OTHER ___ UNKNOWN

OBSERVABLE EFFLUENT: ___ CLEAR ___ CLOUDY ___ BLACK ___ GREY ___ COLORLESS ___ SEPTIC ___ MUSTY ___ NO ODOR ___ NONE ___ NON-OBSERVABLE (STATE REASON IF KNOWN: _____________________________________________________________________________)
LOCATION OF DISCHARGE:
EFFLUENT SAMPLE COLLECTED: Y / N (IF YES, RESULTS : ____________________________________)
STS IS SUBJECT TO THE OPERATION PERMIT PROGRAM: Y / N. IF “YES,” IS OPERATION PERMIT CURRENT: Y / N

AGE OF SYSTEM: ______ YEARS ___ UNKNOWN INITIAL INSPECTION DATE(S): ________________
AGE INFORMATION FROM: ___ HEALTH DEPARTMENT ___ OWNER ___ OTHER (EXPLAIN IN COMMENTS)  VARIANCE: Y/N UNKNOWN

AT TIME OF INSPECTION HOUSE WAS: ___ OCCUPIED ___ INTERMITTENT USE ___ VACANT
HOW LONG: __________________________________________________________________________
NUMBER OF PEOPLE OCCUPYING STRUCTURE IN THE PAST 3 MONTHS: ___________

WATER / WASTEWATER IMPROPERLY ROUTED: Y / N (IF YES, SEE COMMENTS SECTION)

SYSTEM IS DIFFICULT TO EVALUATE DUE TO: ___ DENSE OVERGROWTH ___ SNOW COVER
___ RAIN FALL (OR SNOW MELT) ___ INACCESSIBLE ___ LACK OF RECORDS ___ VACANCY
___ OTHER (EXPLAIN: __________________________________________________________________
WEATHER CONDITIONS: __________________________________________________________________
EXISTING SEWAGE TREATMENT SYSTEM EVALUATION
(CONTINUED)

PROPERTY ADDRESS:
_____________________________________________________________________________________________________________________________________________________________________________________________________________________________________

BASED ON AVAILABLE INFORMATION, THE SEWAGE TREATMENT SYSTEM AT TIME OF INSPECTION:

___ APPEARS TO BE FUNCTIONING AS DESIGNED AND NO NUISANCE WAS OBSERVED.

___ IS CREATING A NUISANCE AND MUST BE BROUGHT INTO COMPLIANCE. PLEASE CONTACT
SUMMIT COUNTY GENERAL HEALTH DISTRICT AT 330-926-5600 FOR FURTHER INSTRUCTIONS.

___ NO NUISANCE OBSERVED AT TIME OF INSPECTION. SEE COMMENTS BELOW:

___ DUE TO VACANCY (OR INTERMITTENT USE) SEWAGE SYSTEM HAS NOT BEEN IN FULL USE
AND MAY NOT SHOW SIGNS OF DEFECTS. A REINSPECTION IS RECOMMENDED ONCE
STRUCTURE IS OCCUPIED FOR A MINIMUM OF SIX MONTHS.

___ SYSTEM IS DISCHARGING HOWEVER EFFLUENT QUALITY COULD NOT BE VIEWED. AN
INSPECTION PORT MUST BE INSTALLED TO DETERMINE EFFLUENT QUALITY. A
REINSPECTION IS REQUIRED AFTER INSPECTION PORT IS INSTALLED.

___ WHEN THIS SYSTEM CREATES A NUISANCE, LEACH WELL MUST BE PROPERLY ABANDONED
AND SYSTEM REPLACED.

___ SYSTEM FALLS UNDER NPDES GUIDELINES AND THEREFORE REQUIRES SUBMISSION OF
APPLICATION FOR TRANSFER OF OHIO NPDES PERMIT FORM TO OHIO EPA, ANNUAL
SAMPLING, & MAINTENANCE OF A SERVICE CONTRACT. NPDES PERMIT TO BE RENEWED ON
A 5-YR CYCLE.

___ ALL OR SOME SYSTEM COMPONENTS UNKNOWN

___ SYSTEM IS DESIGNED TO BE ALTERNATED / DIVERTED. THIS MUST BE DONE REGULARLY.

___ APPEARS TO HAVE SEWER AVAILABLE. PLEASE CONTACT LOCAL SEWER AUTHORITY TO
ENSURE SEWER AVAILABILITY. IF SEWER IS AVAILABLE, STS MUST BE PROPERLY
ABANDONED UNDER A PERMIT FROM SUMMIT COUNTY GENERAL HEALTH DISTRICT, AND
STRUCTURE TIED INTO SEWER.

COMMENTS CONCERNING THIS SYSTEM:
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***AVERAGE LIFE OF A SEPTIC SYSTEM IS 20-25 YEARS. CHANGE IN OCCUPANCY, WATER USAGE, OR
THE REROUTING OF PLUMBING MAY AFFECT FUTURE PERFORMANCE OF THE HOME SEWAGE
TREATMENT SYSTEM.***

INSPECTOR’S SIGNATURE: ___________________________   DATE: ________________

REGISTERED CONTRACTOR’S SIGNATURE (if different from inspector): ___________________________    DATE: _________________________

Page 4
3/2015
PROPERTY ADDRESS: ____________________________________________________________

PRIVATE WATER SYSTEM RECORDS AVAILABLE: Y/N ___ ATTACHED
PRIVATE WATER SYSTEM CONSISTS OF: ___ DRILLED WELL ___ DRIVEN WELL ___ DUG WELL ___ CISTERN ___ SPRING ___ POND ___ OTHER (EXPLAIN: _____________________________________________)

TYPE OF CASING: ___ STEEL ___ PLASTIC ___ OTHER (EXPLAIN: _______________________
CASING DIAMETER: _______ INCHES ___ CASING LENGTH: _______ FEET
CASING IS: ___ OUTSIDE FOUNDATION ___ INSIDE FOUNDATION ___ EXPOSED
(____ INCHES ABOVE FINAL GRADE) ___ WELL PIT ___ UNABLE TO LOCATE (BURIED)
___ OTHER (EXPLAIN: ____________________________________) DEPTH OF WELL: _______ FEET
CAP IS: ___ VERMIN PROOF ___ WELL SEAL ___ NON-VERMIN PROOF
ELECTRICAL CONDUIT IS SEATED/SEALED IN CAP: Y/N
OTHER VISIBLE SIGNS OF CAP BEING NONSEALED: Y/N (IF YES, EXPLAIN: ______________)

ATMOSPHERIC WATER STORAGE TANK(S) USED: Y/N
IF USED, HOW MANY ___ APPROXIMATE SIZE ___ GALLONS ___ LOCATION ___

TYPE OF PUMP: ___ SUBMERSIBLE ___ JET (LOCATION: ______________)
NAME OF PRIVATE WATER SYSTEM INSTALLER: _______________________________________

PRIVATE WATER SYSTEM CONSTRUCTION DATE: ____________

ESTIMATED LOCATION OF WATER SYSTEM, DISTANCE TO (IN FEET): ___ SEWER LINE ___ FOUNDATION ___ PRIMARY SEWAGE TREATMENT ___ SECONDARY SEWAGE TREATMENT ___ PROPERTY LINE ___ OTHER (SEE COMMENTS)
IS PWS ACCESSIBLE FOR CLEANING WITH A DRILLING RIG: Y/N (IF NO, SEE COMMENTS)
IS PWS ACCESSIBLE FOR CHLORINATION: Y/N (EXPLAIN: ____________________________)

TEST RESULTS:

CHLORINE: _______ PARTS PER MILLION TEST METHOD: _____________________________
CONTINUOUS DISINFECTION USED: Y/N (IF YES, TYPE: ______________________________)

BACTERIA SAMPLES: EPA LAB USED:
LOCATION: ______________ RESULT: ACCEPTABLE UNACCEPTABLE DATE: __/__/_____
LOCATION: ______________ RESULT: ACCEPTABLE UNACCEPTABLE DATE: __/__/_____
LOCATION: ______________ RESULT: ACCEPTABLE UNACCEPTABLE DATE: __/__/_____

APPROXIMATE FLOW RATE: ______ GPM VOLUME AT TIME WELL WAS DRILLED
______ GPM INITIAL FLOW DURING INSPECTION ______ GPM AFTER RUNNING FOR 35 MINUTES
LOCATION: _______________________________________________________________
PROPERTY ADDRESS: 

IF REQUESTED: LEAD: ______ ug/L 1ST DRAW ______ ug/L FLUSH 

______ HOURS SINCE LAST USE OF WATER PRIOR TO FIRST DRAW 

NITRATE PRESCREENING: ______ PPM 

NITRATE: ______ mg/L  NITRITE: ______ mg/L 

MAXIMUM CONTAMINATE LEVELS: LEAD = 15.0 ug/L  NITRATE = 10.0 mg/L  NITRITE = 1.0 mg/L 

WOULD PRIVATE WATER SYSTEM MEET THE PRESENT CODE REQUIREMENT IF IT WERE A NEW WATER SYSTEM?  Y/N  (IF NO, EXPLAIN IN COMMENTS SECTION BELOW.) 

BASED ON AVAILABLE INFORMATION IT IS MY OPINION THAT THE PRIVATE WATER SYSTEM IS:

___ ACCEPTABLE FOR SUBJECT PROPERTY
___ ACCEPTABLE FOR SUBJECT PROPERTY, HOWEVER SEE COMMENTS
___ UNACCEPTABLE, HOWEVER ONCE A TOTAL COLIFORM NEGATIVE SAMPLE IS OBTAINED BY AN APPROVED INSPECTOR, THE WATER SYSTEM WILL BE ACCEPTABLE FOR THE SUBJECT PROPERTY.
___ UNACCEPTABLE  (PLEASE CONTACT SUMMIT COUNTY GENERAL HEALTH DISTRICT AT 330-926-5640 FOR FURTHER INSTRUCTIONS) 

COMMENTS CONCERNING THIS SYSTEM: ____________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________
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________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

PLEASE NOTE THAT MANY FACTORS DETERMINE FLOW RATE, SUCH AS: PIPE SIZE, SAMPLE LOCATION, PRESSURE, AND WELL PRODUCTION.

INSPECTOR’S SIGNATURE: ___________________________ DATE: ___________________