

**WABASH COUNTY HEALTH DEPARTMENT**  
89 West Hill Street  
Wabash IN 46992  
Phone: (260) 563-0661 ext. 251; Fax: (260) 563-6082

**COMPLIANCE INSPECTION FOR EXISTING ONSITE SEWAGE DISPOSAL SYSTEM**

**\*\*\*\* SITE DRAWING IS REQUIRED AND MUST BE ATTACHED \*\*\*\***

INSPECTION DATE: \_\_\_/\_\_\_/\_\_\_      PROPERTY OWNER: \_\_\_\_\_

SITE ADDRESS: \_\_\_\_\_

**REASON FOR INSPECTION:**

\_\_\_ Building Permit    \_\_\_ Property Transfer    \_\_\_ Complaint    \_\_\_ Maintenance    \_\_\_ Other: \_\_\_\_\_

ALL WELLS MORE THAN 50' FROM ONSITE SOIL ABSORPTION SYSTEM: \_\_\_ Yes \_\_\_ No

---

**CONDITION OF SEPTIC TANK:**

SIZE OF SEPTIC TANK: \_\_\_\_\_ Gallons      TANK TYPE: \_\_\_ Concrete \_\_\_ Metal \_\_\_ Other: \_\_\_\_\_

TWO COMPARTMENT TANK: \_\_\_ Yes \_\_\_ No    WATER TIGHT: \_\_\_ Yes \_\_\_ No    BAFFLES IN PLACE: \_\_\_ Yes \_\_\_ No

DOES THIS SYSTEM HAVE A DOSING TANK: \_\_\_ Yes \_\_\_ No      SIZE OF DOSING TANK: \_\_\_\_\_ Gallons

TANK TYPE: \_\_\_ Concrete \_\_\_ Metal \_\_\_ Other: \_\_\_\_\_

EFFLUENT PUMP IN PLACE: \_\_\_ Yes \_\_\_ No    PUMP MANUFACTURER: \_\_\_\_\_    MODEL #: \_\_\_\_\_

---

**SOIL ABSORPTION FIELD TYPE:**

\_\_\_ Gravel    \_\_\_ Graveless Trench Type    \_\_\_ Elevated Sand Mound    \_\_\_ Pressure Assisted    \_\_\_ Other: \_\_\_\_\_

SIZE OF SOIL TREATMENT AREA: \_\_\_\_\_      Lineal Feet: \_\_\_\_\_      Square Feet: \_\_\_\_\_

PRE-TREATMENT DEVICE PRESENT: \_\_\_ Yes \_\_\_ No    MANUFACTURER: \_\_\_\_\_    MODEL #: \_\_\_\_\_

SUBSURFACE DRAINAGE (Perimeter Drain): \_\_\_ Yes \_\_\_ No      OUTLET LOCATED: \_\_\_ Yes \_\_\_ No

---

**DID THE INSPECTION REVEAL ANY EVIDENCE OF THE FOLLOWING:**

Surface discharge of sewage effluent to the ground or body of water: \_\_\_ Yes \_\_\_ No

Moist, wet, spongy, or overloaded soil treatment area: \_\_\_ Yes \_\_\_ No

Any evidence of a seepage pit, drywell, or any other non compliant tank or treatment device: \_\_\_ Yes \_\_\_ No

Any Evidence of a sewage backup: \_\_\_ Yes \_\_\_ No

If "yes" was answered to any of the above, please explain: \_\_\_\_\_

---

**TANK MAINTENANCE:**

WAS THE SEPTIC TANK PUMPED:  Yes  No

DATE SEPTIC TANK PUMPERD: \_\_\_\_/\_\_\_\_/\_\_\_\_

GALLONS PUMPED: \_\_\_\_\_ LICENSE NUMBER OF CERTIFIED WASTE HAULER: \_\_\_\_\_

NAME OF COMPANY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

INSPECTION PERFORMED BY:  Same As Above  Other Company: \_\_\_\_\_

NAME OF INDIVIDUAL PERFORMING INSPECTION: \_\_\_\_\_

*To the best of my knowledge, the above information is accurate and a true representation of the onsite sewage disposal system located at this address. I believe this system to be working at this current time, and to the best of my knowledge the system is not in violation of ISDH Rule 410 IAC-6-8.1.*

SIGNATURE OF INSPECTOR: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

PROPERTY OWNER SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

**INFORMATION ON DWELLING:**

NUMBER OF BEDROOMS: \_\_\_\_\_

GARBAGE DISPOSAL:  Yes  No

Number of Occupants: \_\_\_\_\_

**IF OWNER IS CHANGING DWELLING:**

Number of Proposed Bedrooms: \_\_\_\_\_

Garbage Disposal:  Yes  No

**THE WABASH COUNTY HEALTH DEPARTMENT  
CAN NOT GUARANTEE THE SUCCESS OF AN ONSITE SEWAGE DISPOSAL SYSTEM**

DATE REVIEWED: \_\_\_\_/\_\_\_\_/\_\_\_\_

SIGNATURE OF HEALTH OFFICER: \_\_\_\_\_

REVIEWED BY: \_\_\_\_\_

ANY CONCERNS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_