**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

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## 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 #:** _____

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## 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

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## 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:** _____/_____/_____

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**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

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***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:** _____

_____

_____

_____