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 #:** _____

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:** _____/_____/_____

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: _____

_____

_____

_____