



# Connecticut River Area Health District (CRAHD)

PERMIT # \_\_\_\_\_

Old Saybrook   Clinton   Deep River   Haddam   Chester   Killingworth   Durham

FEES: Residential – New \$200 Repair \$150      Commercial – New \$325 Repair \$225

## APPLICATION FOR PERMIT TO CONSTRUCT A SEPTIC SYSTEM (PTC)

*Application is hereby made for an approval to construct a subsurface sewage disposal system for a:*New Residential Septic ☐   or   Repair of Residential Septic ☐      # of Bedrooms \_\_\_\_\_New Commercial Septic ☐   or   Repair of Commercial Septic ☐      Design Flow (GPD) \_\_\_\_\_

Address: \_\_\_\_\_ Map \_\_\_\_\_ Lot \_\_\_\_\_) Town: \_\_\_\_\_

Well ☐   or   Public Water ☐      Garbage Disposal   Y ☐   N ☐      Large Tub   Y ☐   N ☐

Installer Name: \_\_\_\_\_ Company Name: \_\_\_\_\_

Installer Cell Phone: \_\_\_\_\_ Installer License #: \_\_\_\_\_

\*Engineered Design: Y ☐   Name: \_\_\_\_\_   or   N ☐Date of Plan: \_\_\_\_\_ Date of Revision: \_\_\_\_\_      **Proposed System**New Tank & Leaching ☐   New Tank Only ☐   New Leaching Only ☐   Other \_\_\_\_\_

### Proposed Tank(s):

Material: Concrete ☐   or   Plastic ☐      Tank Size: \_\_\_\_\_ gallonsPump Chamber: Y ☐   or   N ☐      Size: \_\_\_\_\_      Grease Trap: Y ☐   or   N ☐      Size: \_\_\_\_\_

### Proposed Leaching

Perc Rate: \_\_\_\_\_ min/in   or   Application Rate: \_\_\_\_\_      Required ELA \_\_\_\_\_      Proposed ELA \_\_\_\_\_

MLSS Calculation: HF \_\_\_\_\_ x FF \_\_\_\_\_ x PF \_\_\_\_\_ = \_\_\_\_\_ feet (Calculation is required with a restrictive layer &lt;60 inches)

Leaching Product: \_\_\_\_\_      Height: \_\_\_\_\_      Total Length: \_\_\_\_\_

Exception(s): Y ☐   or   N ☐      List: \_\_\_\_\_

Applicant (print): \_\_\_\_\_      Sign: \_\_\_\_\_      Date: \_\_\_\_\_

The applicant certifies that the above information is correct, and that construction shall comply with the CT. Public Health Code.

\* Engineer to verify system elevations prior to covering. Engineered as-built required.

### OFFICE USE ONLY

Approved (print): \_\_\_\_\_      Sign: \_\_\_\_\_      Date: \_\_\_\_\_

FEE: \_\_\_\_\_      Cash \_\_\_\_\_      Check # \_\_\_\_\_      Credit/Debit \_\_\_\_\_

Phone: (860) 661-3300

Web: [www.crahd.info](http://www.crahd.info)CT River Area Health District  
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SCAN &amp; PAY

