WEST HAVEN HEALTH DEPARTMENT
355 MAIN STREET, WEST HAVEN CT 06516
PHONE: (203) 937-3660 FAX: (203) 937-3976

SEPTIC AS-BUILT FORM

Address_____ Date of Installation _____ New_____ Repair____ Other _____

Installer Name _____ License# _____ Design Engineer_____

Tank Size _____ (gal) Tank Type: ____ Concrete ____ Plastic ____ New ____Old ____Pump Chamber_____ (gal)

Effective Leaching Area Required: _____sq.ft. Effective Leaching Provided: _____ sq.ft.

Leaching Product Type and Length: _____

Backfill Material: _____ Bottom of System Elevation:_____

Provide elevations: Bench Mark, Sewer at Building, Tank In, Tank Out, Pump Chamber, D-Boxes and Leaching System.

Drawing: Include location of house, sewer at house, and distance from house corners to: septic tank inlet and outlet, pump chamber, D-Boxes, each end of all leaching rows, provide length of leaching rows, location of nearby wells/water lines, street, driveway wastewater treatment system and any other features to help locate system in the future. Include location of any underground utilities near septic system if known.

Bench Mark Location: _____ Bench Mark Elevation: _____

TIE	1	2	3	4	5	6	7	8	9
A									
B									
C									
D									
E									
F									
Elevation									

For Office Use:

Health Official_____ Title_____ Date _____ Permit# _____