



CHESPROCOTT HEALTH DISTRICT  
1247 Highland Ave  
Cheshire, CT 06410  
203-272-2761

## SOIL TESTING APPLICATION

Date: \_\_\_\_\_

Address to be tested: \_\_\_\_\_

Number of Lots to be tested: \_\_\_\_\_

Reason for Testing: (circle) Septic Repair   Single New Lot   Subdivision   B100a

Number of Bedrooms: \_\_\_\_\_ Or Design Flow: \_\_\_\_\_

Owners Name: \_\_\_\_\_ Phone : \_\_\_\_\_

Address: \_\_\_\_\_

Engineer Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Installer Name: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Address: \_\_\_\_\_ License Number: \_\_\_\_\_

APPLICANT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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### OFFICE USE ONLY

Billing Information:

Bill To: \_\_\_\_\_

Date Paid: \_\_\_\_\_ Check #: \_\_\_\_\_ or Cash: \_\_\_\_\_

Date of Testing: \_\_\_\_\_