



CHESPROCOTT HEALTH DISTRICT

1247 HIGHLAND AVENUE • CHESHIRE • CONNECTICUT

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www.chesprocott.org

Maura A. Esposito RS, MPH, Director of Health

APPLICATION for a DEMOLITION PERMIT

Fee: See Fee Schedule for fee. (Payable to Chesprocott Health District)

Residential:_____ **Commercial/Industrial:**_____

Building/Structure Address (Street & Town):_____

Property Owner:_____

Property Owner mailing address:_____

Property Owner phone: _____ **Property Owner email:** _____

Please provide description of demolition project:

Provide details of what will occur with existing well and septic system:

Demolition Contractor:

Company Name:_____

Address:_____

(Street, City, State, Zip Code)

Telephone:_____

(Include area code)

Remarks:_____

Staff Review Only

_____**APPROVED OR** _____**DENIED by (Sanitarian)**_____ **Date**_____