



CHESPROCOTT HEALTH DISTRICT
 1187 Highland Avenue, Suite 210
 Cheshire, CT 06410
 203-272-2761

SOIL TESTING APPLICATION

Date: _____

Address to be tested: _____ **Town:** _____

Number of Lots to be tested: _____

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

Owners Name: _____ **Phone :** _____

Address: _____

Engineer Name: _____ **Office Phone:** _____

Address: _____ **Contact Person:** _____

Installer Name: _____ **Cell Phone:** _____

Address: _____ **License Number:** _____

APPLICANT SIGNATURE: _____ **DATE:** _____

New Lots: Minimum 3 deep pits & perc in Primary; 2 deep pit & perc in Reserve
B-100's and Repairs: 2 deep pits and perc

OFFICE USE ONLY

Date Paid: _____ **Check #:** _____ **or Cash:** _____

Appointment Date: _____ **Time:** _____