

CAROLINE COUNTY HEALTH DEPARTMENT

Division of Environmental Health (410/479-8045) Please allow minimum of 30 days processing time.

P.O. Box 10, Denton, Maryland 21629



APPLICATION FOR WATER SUPPLY AND/OR SEWAGE VERIFICATION

(Per COMAR 26.04.02.02D) This application required for any/all improvements on property.

DIRECTIONS: Complete sections A-E, attach a \$40 non-refundable fee. Please make check payable to "Caroline County Health Department" and mail to address above; or bring to 403 S 7th Street, Denton (Room 210, upstairs in HAPS Building). SITE PLAN MUST ACCOMPANY THIS APPLICATION—REFER TO ITEM C.

INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED

A) Current Owner: \_\_\_\_\_

Day Phone # \_\_\_\_\_

Street or P.O. Box \_\_\_\_\_

Cell Phone #: \_\_\_\_\_

(Mailing address)

City/State/ZIP: \_\_\_\_\_

Sub'd name: \_\_\_\_\_

B) Property Location: \_\_\_\_\_

(911 street address)

Map Block Parcel (Lot)

C) Stake proposed improvements and submit a scaled drawing of existing property lines, buildings, driveway, well(s), septic system(s), in addition to proposed building(s). (Will accept "survey" from settlement papers—sometimes referred to as "Improvements Survey", "Location Survey" or "Plot Plan"—it shows property lines and existing buildings)

D) Check off proposal(s): [ ] accessory dwelling, [ ] addition, [ ] deck, [ ] farm buildings, [ ] pool, [ ] shed, [ ] sidewalks, [ ] special use or change of use exception [ ] lot line revision or subdivision review, [ ] SRA revision, [ ] home occupation business, [ ] Other, specify: \_\_\_\_\_

GIVE DIMENSIONS AND DETAILS BELOW:

Blank lines for providing dimensions and details.

X \_\_\_\_\_

E) Owner's Signature (or agent authorized in writing)

Date

THIS SECTION TO BE COMPLETED BY CAROLINE COUNTY HEALTH DEPARTMENT

This verification is provided in accordance with COMAR 26.04.02.02D. This represents information provided by the owner, health department records and/or a sanitarian site visit. No statements can be made regarding whether the systems have been or will be properly operated and maintained.

H. D. COMMENTS: \_\_\_\_\_

Blank lines for providing comments.

Registered Sanitarian: \_\_\_\_\_ Date: \_\_\_\_\_ (of results)

Receipt # \_\_\_\_\_

Date Pd \_\_\_\_\_

WSV [ ] Approved [ ] Disapproved \*

Copy to: PERMITTING AGENCY \* Changed to Approved per: \_\_\_\_\_

TN# \_\_\_\_\_