

STS Alteration Application

Fee Paid _____

Date _____

Receipt # _____

Received by _____

Alt # _____

 Residential Commercial

STS Location	No. of Bedrooms	Township/Village/City
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Job description: _____

Applicant/Agent

Name _____

Mailing address _____ Phone _____

City _____ State _____ Zip _____

Owner

(If different from above)

Name _____

Mailing address _____ Phone _____

City _____ State _____ Zip _____

By my signature below I certify that I have read, I understand, and I agree to comply with the conditions set forth on the reverse hereof.

Applicant's Signature_____
Date-----
Sanitarian Remarks: __________
Sanitarian's Signature_____
Date

OWNER MUST READ AND INDICATE AGREEMENT BY SIGNING ON THE FRONT:

I understand that any approval granted on the basis of false or inaccurate information is automatically revoked. Approval is similarly revoked for my failure to comply with any requirements or conditions herein or any additional requirements of the Hamilton County Board of Health or the State of Ohio.

I agree to have a Registered Installer obtain a Sewage Treatment System (STS) Alteration Permit prior to starting any work on the existing STS. I understand that THIS APPLICATION EXPIRES 5 YEAR FROM THE APPROVED DATE, and no alteration permit will be issued after that date. If the application expires, I must re-apply for a new permit and pay another application fee.

I understand that if the system has electrical components, a permit and inspection approval must be obtained from the Local Building Inspection Department prior to issuance of the final STS alteration approval and operational permit.

I understand that the STS and all components contained within it require routine maintenance. Therefore, I agree to operate, maintain, and service the system and its components in accordance with any and all rules or requirements of the Hamilton County Board of Health and the State of Ohio. Depending on the STS type, an operation, monitoring, maintenance and service contract with a Registered Service Provider may be required before final system alteration approval is granted.

All STS require an Operational Permit from the Hamilton County General Health District. I understand that Health District Personnel will monitor this STS as often as necessary to obtain information and to verify that the system is functioning in a satisfactory manner so that an Operation Permit may be issued. I understand that actions of Health District inspectors, engaged in the evaluation and determination of measures required for the siting, design, installation, and monitoring of this STS, shall in no way be taken as guarantee that the system will function in a satisfactory manner for any given period of time, or that the Hamilton County General Health District or any of its agents or employees assume any liability for damages, consequential or direct, which are caused, or which may be caused by a malfunction of the STS.

In the event that the STS fails to function in a satisfactory manner, as determined by the Hamilton County General Health District, I will take immediate action to correct any malfunctions, ensuring that the system functions in a satisfactory manner.

I hereby certify that the proposed work is authorized by the owner of record. If I am signing this application as the owner's authorized agent, we have agreed to conform to all applicable laws of the State of Ohio and the regulations of the Hamilton County General Health District.