



Verification of Individual Well Supply

*Health Department Use Only-
Validation*

- Single Family
- Child Care

- Adult Family Homes
- Boarding Homes

Site Address: _____

Parcel Number: _____

Applicant Name: _____

Mailing address: _____

City: _____ State: ____ Zip: _____

Phone #: _____ Fax #: _____

Please provide a description of your proposal.

Please provide a site plan.

OSS Review required by Health Department YES _____ NO _____

Verification by Health Department Water Program:

Test Results for Bacteria (less than one year old): _____ Date: _____

Test Results for Nitrate (less than three years old): _____ Date: _____

Other Water Test Results: _____ Date: _____

- The above individual well supply **is able** to provide water to the above project.
- The above individual well supply is **not able** to provide water to the above facility.

Approved by _____

Approval Date _____

Expiration Date _____