Darke County General Health District

SEPTIC PUMPING REPORT FORM

***ATTENTION* This is not a septic inspection nor will constitute one.**

The information contained in this report reflects the observations recorded at the time the system was pumped and includes any actions completed by the registered septic hauler. This report shall not be construed as a declaration of approval or disapproval or the proper function of the system.

Pumping Date:	County:	Township:
Pumping Location Address (include city & zip)		
Name of person making Request: ☐ Check if this person is the owner		Phone #

TANK PUMPING INFORMATION	☐ Residential ☐ Commercial	# of Tanks: _____	Total Gallons Pumped: _____ gal.

Check all that apply. If multiple tanks, number the tanks in order beside the tank type. More than one of the same types should also be numbered in succession.

☐ Septic _____ ☐ Aeration _____ ☐ Holding _____ ☐ Dosing ____ ☐ Privy Vault_____ ☐ Portable Tank _____ ☐ Other _____ Type: _____

If applicable what type of Aeration tank? _____ Was the aeration motor? ☐ Present ☐ Missing ☐ Unplugged / No Electric

Give the volume of each tank pumped: Tank 1 _____ gal Tank 2 _____ gal Tank 3 _____ gal Tank 4 _____ gal

TANK CONDITION OBSERVATIONS

Tank Condition ☐ Good ☐ Poor ☐ Could not determine If poor, which tank? _____ Evidence of Leaking? ☐ No ☐ Yes, tank # _____

Inlet Riser: ☐ Present ☐ Absent, tank # _____

Middle Riser: ☐ Present ☐ Absent, tank # _____

Outlet Riser: ☐ Present ☐ Absent, tank # _____

Splitter Box Riser: ☐ Present ☐ N/A ☐ Absent, how many _____

Distribution Box Riser: ☐ Present ☐ N/A ☐ Absent, how many _____

8 Inch Inspection Port: ☐ Present ☐ N/A ☐ Absent

Curtain Drain Inspection Port: ☐ Present ☐ N/A ☐ Absent

High Water levels at time of pumping: ☐ No ☐ Could not determine ☐ If yes, tank # _____

Evidence of previous high water levels: ☐ No ☐ Could not determine ☐ If yes, tank # _____

Other solids removed: ☐ Filter Media ☐ Peat ☐ Other: _____

Was dewatering necessary: ☐ N/A ☐ No ☐ Yes, _____ gal

Solid Waste Facility taken to: _____

Did spillage occur during pumping process? ☐ Yes ☐ No

If yes, was area properly cleaned and disinfected? ☐ Yes ☐ No

Risers Condition (All): ☐ Good ☐ Poor, which riser? _____

Inlet Baffle: ☐ Present ☐ Absent, tank # _____

Outlet Baffle: ☐ Present ☐ Absent, tank # _____

Effluent Filter: ☐ N/A If present, was it cleaned? ☐ Yes ☐ No

Condition of Splitter Box: ☐ Good ☐ Poor, which one? _____

Condition of Distribution Box: ☐ Good ☐ Poor, which one? _____

High Water levels in Curtain Drain or Inspection Port: ☐ Yes ☐ No

High Water levels in Distribution Box: ☐ Yes ☐ No

Did it rain in the last week? ☐ Yes ☐ No

Drainage Issues: ☐ Yes ☐ No

Is the tile in poor condition or clogged? ☐ Yes ☐ No

~~***A copy of this report shall be provided to the Sewage Treatment System Owner and the Local Health Department**~~

List all repairs, Additional Work and Comments:

Disposal Location: ☐ Waste Water Treatment Facility **Name of Facility:** _____

☐ Land Application **Permit #:** _____ **Address:** _____

Driver/Technician Name (printed) **Company Phone #**

Septic Hauling Company: **Registration #**

YOUR TANK(S) IS RECOMMENDED FOR SERVICE AGAIN IN: _____ YEARS _____ MONTHS

REGULAR MAINTENANCE IS NECESSARY TO PROLONG THE USEFUL LIFE OF YOUR SEWAGE TREATMENT SYSTEM.