

***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: <input type="checkbox"/> Check if this person is the owner		Phone #

TANK PUMPING INFORMATION	<input type="checkbox"/> Residential <input type="checkbox"/> 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.			
<input type="checkbox"/> Septic _____ <input type="checkbox"/> Aeration _____ <input type="checkbox"/> Holding _____ <input type="checkbox"/> Dosing _____ <input type="checkbox"/> Privy Vault _____ <input type="checkbox"/> Portable Tank _____ <input type="checkbox"/> Other _____ Type: _____			
If applicable what type of Aeration tank? _____ Was the aeration motor? <input type="checkbox"/> Present <input type="checkbox"/> Missing <input type="checkbox"/> 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 <input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Could not determine If poor, which tank? _____ Evidence of Leaking? <input type="checkbox"/> No <input type="checkbox"/> Yes, tank # _____	
Inlet Riser: <input type="checkbox"/> Present <input type="checkbox"/> Absent, tank # _____ Middle Riser: <input type="checkbox"/> Present <input type="checkbox"/> Absent, tank # _____ Outlet Riser: <input type="checkbox"/> Present <input type="checkbox"/> Absent, tank # _____ Splitter Box Riser: <input type="checkbox"/> Present <input type="checkbox"/> N/A <input type="checkbox"/> Absent, how many _____ Distribution Box Riser: <input type="checkbox"/> Present <input type="checkbox"/> N/A <input type="checkbox"/> Absent, how many _____ 8 Inch Inspection Port: <input type="checkbox"/> Present <input type="checkbox"/> N/A <input type="checkbox"/> Absent Curtain Drain Inspection Port: <input type="checkbox"/> Present <input type="checkbox"/> N/A <input type="checkbox"/> Absent High Water levels at time of pumping: <input type="checkbox"/> No <input type="checkbox"/> Could not determine <input type="checkbox"/> If yes, tank # _____ Evidence of previous high water levels: <input type="checkbox"/> No <input type="checkbox"/> Could not determine <input type="checkbox"/> If yes, tank # _____ Other solids removed: <input type="checkbox"/> Filter Media <input type="checkbox"/> Peat <input type="checkbox"/> Other: _____ Was dewatering necessary: <input type="checkbox"/> N/A <input type="checkbox"/> No <input type="checkbox"/> Yes, _____ gal Solid Waste Facility taken to: _____ Did spillage occur during pumping process? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, was area properly cleaned and disinfected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Risers Condition (All): <input type="checkbox"/> Good <input type="checkbox"/> Poor, which riser? _____ Inlet Baffle: <input type="checkbox"/> Present <input type="checkbox"/> Absent, tank # _____ Outlet Baffle: <input type="checkbox"/> Present <input type="checkbox"/> Absent, tank # _____ Effluent Filter: <input type="checkbox"/> N/A If present, was it cleaned? <input type="checkbox"/> Yes <input type="checkbox"/> No Condition of Splitter Box: <input type="checkbox"/> Good <input type="checkbox"/> Poor, which one? _____ Condition of Distribution Box: <input type="checkbox"/> Good <input type="checkbox"/> Poor, which one? _____ High Water levels in Curtain Drain or Inspection Port: <input type="checkbox"/> Yes <input type="checkbox"/> No High Water levels in Distribution Box: <input type="checkbox"/> Yes <input type="checkbox"/> No Did it rain in the last week? <input type="checkbox"/> Yes <input type="checkbox"/> No Drainage Issues: <input type="checkbox"/> Yes <input type="checkbox"/> No Is the tile in poor condition or clogged? <input type="checkbox"/> Yes <input type="checkbox"/> No

<u>List all repairs, Additional Work and Comments:</u>	
Disposal Location: <input type="checkbox"/> Waste Water Treatment Facility Name of Facility: _____	
<input type="checkbox"/> 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.	

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