For the fee amount please see the fee schedule at http://www.fairfieldct.org/health or speak with a Sanitarian.

Date:______________

Soil Test:______________

Receipt #:______________

Town of Fairfield

HEALTH DEPARTMENT
725 Old Post Road
Fairfield, Connecticut 06824

Sands L. Cleary
Director of Health

Phone (203) 256-3020
Fax (203) 254-8850

APPLICATION

SEPTIC SYSTEM SOIL TEST

_____ (Please Initial) I understand that the issuance of this permit does not relieve me of the obligation to comply with the regulations, codes or ordinances of other Town departments such as, but not limited to, the Building, Zoning or Conservation Departments.

Applicant's Name: ______________________________ **Business Name (If Applicable)** ______________________________

Address: ____ **Phone #** ________________________

Applicant's Signature: ____

Excavator: ____ **Tester:** _________________________________

Developer's Lot # _________ **House #** ____________ **Street** ____

Owned by: ____

Issued by: ____ ___________________________________

Title **Date**

Inspection Date(s) & Sanitarian's Initials ____

Percolation Data

Hole		Hole		Hole		Hole	
Time	Reading	Time	Reading	Time	Reading	Time	Reading

Deep Test Hole Data

PIT	PIT	PIT	PIT

Use reverse side for comments and/or recommendations

Rev. 01-2018