ONSITE WASTEWATER TREATMENT SYSTEM (OWTS)
REPAIR AND REMEDIATION DATA FORM

Municipality:________________________

Property Mailing Address (No. & Street):____

Town/ Village:____State:______________________Zip:_______

Owner: ____

Owner Mailing Address (No. & Street) (if different):____

Town/ Village:____State:__________________Zip:________

Property Use: [] Single Family [] Multi-Family [] Industrial [] Commercial

[] Other - Describe:__________________________________

OWTS Remediation ☐ **WCDH File #:_____________**

Remediation shall mean installation, replacement, or expansion of onsite wastewater treatment system components to correct an OWTS failure, or impending failure, resulting in, or that may result in, the discharge of sewage or domestic wastes or trade wastes or offensive material on to the surface of the ground, into a storm sewer, or into a watercourse or water body. Remediation shall not include repairs, as defined above, to correct an OWTS failure.

OR

OWTS Repair ☐ **Complete the following information.**

Repair shall mean the repair, maintenance, and replacement in kind and in situ; of broken, damaged, or worn onsite wastewater treatment system components.

Number of Bedrooms_______ Number of Bathrooms:______ Water Supply Type: Public ☐ Well ☐

Please note below only components that have been repaired or replaced.

Repaired	Replaced	
☐	☐	House Sewer or other Solid Pipe(s)
☐	☐	Septic Tank#1 Size(gallons): _______
☐	☐	Septic Tank#2: Size (gallons): _______
☐	☐	Junction/Distribution Box(es)
☐	☐	Sewage Pump(s) or other Dosing Equipment
☐	☐	Absorption Trench Length _______ ft. X Trench Width _______ft
☐	☐	Seepage Pit(s)
☐	☐	Galley(s)
☐	☐	Gravelless Trench(es)
☐	☐	75-A Alternative System
☐	☐	Other Advanced Alternative System
☐	☐	Other System Component(s) - Describe:____

DRAW BUILDING AND LOCATION OF WORK PERFORMED ON BACK OF THIS FORM

☐ **Entire System Replaced**

- -

Contractor's Name (print): ____________________________________ Date Repair/Remediation Completed: ___________

Contractor's Signature:____ License No.:_________

Upon completion please remit to:

Westchester County Department of Health- BEQ
145 Huguenot Street-7th Floor
New Rochelle, NY 10801
Attn: Patricia Tornello-Adams

Repair File #:REP____________
(WCDH Staff only)

(2/09)