Clark County Health Department

1320 Duncan Avenue **phone: (812) 282-7521**
Jeffersonville, IN 47130 **fax: (812) 288-2711**
website: www.clarkhealth.net

APPLICATION
PRIVATE SEWAGE DISPOSAL SYSTEM
INSTALLER PERMIT

HEALTH DEPARTMENT RECORDS INDICATE THAT YOUR PERMIT # _____
TO INSTALL/REPAIR ON-SITE SEWAGE DISPOSAL SYSTEMS WITHIN CLARK COUNTY, EXPIRES ON:

_____

INFORMATION YOU PROVIDE ON THIS APPLICATION WILL BE MADE AVAILABLE TO THE PUBLIC. IF REQUESTED, THIS DEPARMENT WILL FURNISH THE PUBLIC A LIST CONTAINING CURRENT PERMIT HOLDERS, THEIR NAMES, ADDRESSES AND PHONE NUMBERS (BUT NOT E-MAIL ADDRESSES).

IF YOU WISH TO CONTINUE TO BE PERMITTED TO INSTALL WITHIN CLARK COUNTY, PLEASE COMPLETE THIS APPLICATION AND CORRECT ANY ERRORS APPEARING ON THE FORM AND RETURN IT ALONG WITH YOUR PAYMENT OF $50.00 FOR THE NEW PERMIT FEE.

BUSINESS NAME: _____

OWNERS NAME: _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____ **PHONE** _____

CHAPTER 7-1-1 (A) OF THE CLARK COUNTY SANITARY CODE (CCSC) HAS ESTABLISHED, "NO PERSON SHALL INSTALL, CONSTRUCT, ALTER OR REPAIR AN ON-SITE SEWAGE DISPOSAL SYSTEM UPON ANY PROPERTY IN CLARK COUNTY, INDIANA, WITH OR WITHOUT CHARGE: (1) WITHOUT FIRST OBTAINING AND POSSESSING A CURRENT, UNREVOKED PERMIT FROM THE HEALTH OFFICER, EXCEPT AS PROVIDED BY 7-2-2; OR , (2) UPON ANY PROPERTY FOR WHICH AN ON-SITE SEWAGE DISPOSAL SYSTEM PERMIT HAS NOT BEEN ISSUED BY THE BOARD OF HEALTH AS REQUIRED BY CHAPTER 6 OF THE SANITARY CODE."

CHAPTER 7-2-1 (B) OF THE (CCSC) STATES, "ONLY ONE (1) PERMIT SHALL BE REQUIRED FOR EACH PERSON OR OTHER SEPARATE LEGAL ENTITY ENGAGED IN INSTALLATION, ALTERING OR REPAIRING, WITH OR WITHOUT CHARGE, OF AN ON-SITE SEWAGE DISPOSAL SYSTEM."

EACH PERMIT REQUIRED BY CHAPTER 7 OF THE SANITARY CODE, SHALL BE ISSUED BY THE HEALTH OFFICER FOR A TERM OF ONE (1) YEAR (BEGINNING JUNE 30th AND ENDING JUNE 30th THE FOLLOWING YEAR) AND MAY BE RENEWABLE UPON APPLICATION AND ALL APPLICABLE FEE(S) REQUIRED BY CCSC 7-3-1.

ANNUAL PERMIT FEE $50.00

PLEASE PRINT: [please provide e-mail address] _____

NAME / TITLE OF APPLICANT: _____

SIGNATURE: _____

<<<<<<<<<<<<<< FOR HEALTH DEPARTMENT USE ONLY >>>>>>>>>>>>>>>

DATE ISSUED _____ ISSUED BY: _____ PERMIT# _____

RECEIPT#: _____