



SAN BENITO COUNTY

GAIL NEWEL, M.D., MPH
HEALTH OFFICER

JIM RYDINGSWORD
DIRECTOR

HEALTH & HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES
Healthy People in Healthy Communities

SEWAGE DISPOSAL SYSTEM PERMIT APPLICATION

DATE: _____

FEES ARE NON-REFUNDABLE

HAVE YOU APPLIED FOR A BUILDING PERMIT? ____ YES ____ NO

CHECK ONE: ____ NEW SYSTEM \$852.00
____ MAJOR REPAIR (BOTH TANK & DRAINFIELD) \$852.00
____ MINOR REPAIR (TANK OR DRAINFIELD) \$442.00
____ ENGINEERED INDIVIDUAL SYSTEM \$976.00
____ COMMERCIAL SYSTEM \$1097.00
____ ALTERNATIVE / INNOVATIVE SYSTEM \$2,129.00
____ SEPTIC SYSTEM ABANDONMENT \$145.00

PROPERTY OWNER'S NAME _____ PHONE # _____

MAILING ADDRESS _____

SITE ADDRESS _____

***ASSESSOR'S PARCEL NO. _____ (MUST BE COMPLETED)

WATER SOURCE _____ NUMBER OF WATER SERVICE CONNECTIONS _____

NO. OF BEDROOMS ____ NO. OF POTENTIAL BEDROOMS ____ GARBAGE DISPOSAL - YES / NO
(CIRCLE ONE)

LOCATION OF PROPOSED SEWAGE DISPOSAL SYSTEM (FEET) FROM:

DWELLING _____ PROPERTY LINE _____
WELLS _____ WATER COURSE _____
SLOPE OF PROPERTY _____

AN ACCURATE PLOT PLAN SHALL BE SUBMITTED WITH THIS APPLICATION. (THE SEWAGE DISPOSAL SYSTEM AS WELL AS THE 100% EXPANSION AREA SHALL BE NOTED).

THE APPLICANT SHALL NOTIFY THE ENVIRONMENTAL HEALTH DEPT. PRIOR TO INSTALLATION OF SYSTEM AND PROVIDE THE NAME AND THE CONTRACTOR'S LICENSE NUMBER OF THE INSTALLER.

****PLEASE PROVIDE THE FOLLOWING INFORMATION IF KNOWN WHEN APPLICATION IS SUBMITTED.**

NAME OF CONTRACTOR/INSTALLER _____

LICENSE NUMBER _____ PHONE # _____

COMPLETE MAILING ADDRESS _____

NOTE: IF FALSE INFORMATION IS SUBMITTED, PERMIT SHALL BE VOID.

PROPERTY OWNER'S SIGNATURE _____

PUBLIC HEALTH SERVICES
439 Fourth Street
Hollister, CA 95023
831-637-5367

MEDICAL THERAPY UNIT
761 South Street
Hollister, CA 95023
831-637-1989

ENVIRONMENTAL HEALTH SERVICES
351 Tres Pinos Road, Ste C-1
Hollister, CA 95023
831-636-4035

HEALTH EDUCATION PROGRAMS
439 Fourth Street
Hollister, CA 95023
831-637-5367