



SAN BENITO COUNTY

HEALTH & HUMAN SERVICES AGENCY

PUBLIC HEALTH SERVICES
Healthy People in Healthy Communities

Aboveground Storage Tank (AST) Removal/Closure Permit Application

Date: _____

Fee: \$562.00

Facility Name: _____

Address: _____

Contact Person: _____ Phone Number: _____

Assessor's Parcel Number: _____

Removal Contractor: _____

Contractor's License No.: _____ Type of License: _____

Address: _____

Contact Person: _____ Phone Number: _____

Name & Phone number of firm that will take soil and/or water samples:

Name & Phone number of laboratory that will analyze soil and/or water samples:

This permit expires 90 days from the date of closure plan approval.

Tanks to be removed:

Name of certified hazardous waste hauler: _____

Contact Person: _____ Phone Number: _____

Destination of tank(s): _____

Size

Tank Content

Tank 1 _____

Tank 2 _____

Tank 3 _____

A detailed layout of your underground storage tank facility shall accompany this application.

A closure report shall be submitted to this office within thirty (30) days of tank(s) removal.

Facility owner's signature: _____