TOWN OF MADISON HEALTH DEPARTMENT 8 CAMPUS DRIVE, MADISON, CT 06443

PROPOSED SEPTIC SYSTEM REPAIR FORM

ADDRESS: ____ # BEDROOMS: ____

INSTALLER: ____ DATE:____

PERC RATE: ____ TOTAL SQ FT REQUIRED: _____________________________________

New leaching product ___________ - Length ____ - Sq ft credit____ - TOTAL SQ FT PROVIDED: _____________________________________

Max. depth below existing grade (bottom of system)____

Tank Size___________________ - new ____ - old ____ Fill Required: ___yes ___no

Connect to old system? ___yes ___no HLO from old _________ HLO to old _________ Level _________

Describe old system:____ Credit for old________

MLSS Required________; MLSS Provided________.