



Yakima Health District

1210 Ahtanum Ridge Drive
 Union Gap, Washington 98903
 Phone (509) 575-4040
 Fax (509) 575-7894

<http://www.yakimahealthdistrict.org>

For Office Use:	
CASE # _____	
Date _____	Initial _____
Amt _____	Check# _____
Code _____	Rec# _____

ON-SITE SEWAGE SYSTEM – SEPTIC CLEARANCE PERMIT APPLICATION

Please attach a complete site plan with structures and measurements clearly represented

Yakima Co. Building Permit Case #: _____

PARCEL # _____	Project Description _____
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Applicant Name Information:	Property Owner Name (if different):
Applicant Name: _____	Owner Name: _____
Address: _____	Address: _____
City, State, Zip: _____	City, State, Zip: _____
Phone: _____	Phone: _____
Email Address: _____	Email Address: _____
Contact information (if different from above): _____	

Service and Fees			
Clearly mark your selection in the right column			
Septic Clearance (existing systems only) FIRST STEP IN BLD CASE CLEARANCE PROCESS, INVOLVES ONSITE INSPECTION DETERMINING SEPTIC LOCATION	\$149	H_HOS004	<input type="checkbox"/>
Existing System Evaluation REQUIRES UNCOVERING OF LATERAL ENDS, TANK AND DISTRIBUTION BOX WITH PUMPING RECORDS PROVIDED. DETERMINES THE EXISTING SYSTEM CAPACITY AND LOCATION	\$410	H_HOS019	<input type="checkbox"/>

- Lot Size (dimensions) _____
- Building Type (check one): Single Family Residence Addition Outbuilding/slab
- Number of Bedrooms _____ Number of people using the system in 24 hours _____
- Source of water: individual well Community well 2-Party Well
If on a community well, provide ID#, name of water system _____
- Is City Sewer available? yes no How far away? _____ (feet)

Allow 7 to 10 working days for clearance approval.

My signature certifies that this information is accurate to the best of my knowledge. I grant permission for the Yakima Health District to make reviews or inspections required by the permit process. I understand that this application will become part of the public record and that any decision made by the Yakima Health District may be appealed provided that the appeal is made in writing and delivered to the Health District within 30 days of the decision. I also understand that supplying incorrect and/or incomplete information may result in delays in completing your requests, permit revocation, and/or additional costs. Onsite evaluations may extend the time for final approval.

Applicant Signature _____

Date _____