



YAKIMA HEALTH DISTRICT
1210 Ahtanum Ridge Drive, Union Gap, WA 98903

**APPLICATION FOR
DAY CARE SEPTIC CAPACITY REVIEW**

If you need help or have questions,
contact Environmental Health at:
(509) 249-6508
(800) 535-5016, extension 508
Fax (509) 576-7416
<http://www.yakimapublichealth.org>

FOR OFFICE USE ONLY
Date _____ Amount/Code _____
Receipt # / Initials _____ Ck # _____
Comments _____

PLEASE PRINT CLEARLY

APPLICANT INFORMATION

(Name)

(Address)

(City, State, Zip)
Phone: Home _____ Work _____

LAND OWNER INFORMATION

(Name)

(Address)

(City, State, Zip)
Phone: Home _____ Work _____

- 1. Site Tax Parcel Number: _____
- 2. Day Care Address: _____
(Street/Road) (City)
- 3. Occupancy:
 - A. Number of People Living in the House: _____
(Include children who are full time residents)
 - B. Number of Children Proposed for Day Care Facility License: _____
(Do not include children already counted in 'A' above)
 - C. Number of Workers at Day Care Facility: _____
(Do not include workers already counted in 'A' above)
- 4. Building Type: Single Family _____ Multi-Family _____ Commercial _____
- 6. Number of Bedrooms: _____
- 7. Water Service: Individual Well _____ Community Well _____ 2-Party Well _____ City Water _____
If Community Well: ID#: _____
Well Name: _____
of Connections: _____

Day care septic capacity reviews involve the review of existing records and supplied information. If we do not have a record of the existing septic system, we cannot complete the review. A record of the existing septic system can be developed by doing an existing system evaluation which involves additional fees, owner system preparations, and site visit(s).

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 approval process. I understand that this application will become part of the public record. I understand 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 the review and/or invalidate any approvals.

Applicants Signature _____ Date _____