



Toledo-Lucas County Health Department  
 635 N Erie Street  
 Toledo, Ohio 43604  
 Phone: 419-213-4100 ext. 4  
 Fax: 419-213-4141  
 Website: [www.lucascountyhealth.com](http://www.lucascountyhealth.com)

## APPLICATION FOR SEWAGE TREATMENT SYSTEM **INSTALLATION, REPLACEMENT PERMIT**

### PROPERTY INFORMATION

Owner/Applicant		Township (of property)	
Mailing Address	City	Zip Code	
Email	Phone #		
Property Address	Zip Code		
Parcel Number, if known	Water Supply (city, well, other)		
<input type="checkbox"/> Single Family <input type="checkbox"/> Multiple Family <input type="checkbox"/> SFOSTS           Other _____	Number of Bedrooms:	Basement: Yes        No	

### PERMIT TYPE REQUESTED (Check all that apply)

### FEE:

#### Household Sewage Treatment System

- ☐ New Installation ..... **\$774.00 (\$460 License Fee+\$74 State Fee+\$240 O&M Fee**
- ☐ Replacement..... **\$774.00 (\$460 License Fee +\$74 State Fee+ \$240 O&M Fee**  
**\$534.00 (If already submitting O&M Fee)**

(The abandonment permit is included for an existing system, that is being pulled for a replacement.)

INSTALLER INFORMATION	
Name	Email
Registration #	Phone #

### ADDITIONAL INFORMATION

- 1) Application shall be filled out completely and applicant/owner must be able to substantiate all data.
- 2) A permit will not be granted unless the sewage treatment installation can conform to the rules of the Ohio Department of Health governing such installation (Ohio Administrative Code 3701-29).
- 3) Must have approved Design and Site approval prior to making application for installation permit (Design and Site Reviews are valid for five (5) years from date of approval).
- 4) Installation Permit expires one (1) year from date of application.
- 5) Refunds are not permitted.

**This application will not be processed unless accompanied by the required fee(s).**

**\*\* Make Checks Payable to the Toledo-Lucas County Health Department or TLCHD \*\***

<b>By signing below I acknowledge that I have read and agree to all terms and conditions on this application and that to the best of my knowledge all the information provided with this application is factual.</b>	
Owner/ Applicant Signature:	Date:

### -----Health Department Use Only-----

Received by:				Date:	
Local Fee	State Fee	Total Fee	Receipt #	ODH Audit #	Permit #

NOTES:

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