

TOWN OF NELSON

APPLICATION FOR CONSTRUCTION OR MODIFICATION OF
RESIDENTIAL SEPTIC SYSTEM

Fee _____ Permit Approved By _____

Permit No _____ Date _____

Applicants Name _____

Applicants Address _____

Applicants Phone Number _____

APPLICATION FOR: Construction of New System _____

Modification of Existing System _____

Property Location _____

Property Owner _____

Property Tax Map Number _____

Note: In order to conform to the standards set by the New York State Department of Health (NYSDH), Parts 1, 2, and 3 of this Application must be completed, and this information submitted to the Zoning Enforcement Officer prior to issuance of a permit allowing construction of a new on-site Residential Sewage Disposal System within the Township of Nelson.

The information necessary for a Modification of Existing System - Permit shall be as directed by the Zoning Enforcement Officer.

NOTICE THE APPLICANT SHALL NOTIFY THE CODES OFFICER AT LEAST FOUR (4) BUSINESS DAYS IN ADVANCE OF THE EXPECTED TIME OF COMPLETION OF A WASTE DISPOSAL SYSTEM THAT A SYSTEM IS READY FOR FINAL INSPECTION.

Application
for
On-Site Residential Sewage Disposal System

Part 1. Soil Investigation

At least two test holes, widely spaced, shall be dug within the proposed leaching area to insure that uniform soil and site conditions prevail.

Each test hole shall be at least 5' deep and 2' square at the bottom.

Depth to bedrock, if any observed _____

Depth to seasonal high groundwater _____

Date performed: _____

Observed by: _____

Soil Profile Observation Information should include depth, texture, structure, color and soil saturation for each test hole, presented in the following format:

Soil Pit No. _____

Depth
(Ft.)

	TEXTURE	STRUCTURE	COLOR	SOIL SATURATION
0	Silt Loam	Granular		
		Platy		
2	Silt Clay Loam	Blocky	Brown	None
	Clay Loam			
4	Sandy Loam	Platy		
	↓			
6				

Note: The test holes are not to be used to perform percolation tests.

APPLICATION

FUR

ON-SITE RESIDENTIAL SEWAGE DISPOSAL SYSTEM

Part 2. Soil Percolation Tests

Note: These tests shall be done in accordance with the procedures set forth in the NYSDM Waste Treatment Handbook, pages 7 and 8.

There shall be a minimum 12-hour pre-soak period.

Describe Pre-Soak Process:

Date and time of day of Pre-soak:

Start _____
Finish _____

Date and time of day of Perc. test:

Start _____
Finish _____

Stabilized percolation Rate _____

Percent of slope on the building lot _____

Performed by: _____

Copies of Percolation Test Data Forms should be attached to this application.

Application
for
On-Site Residential Sewage Disposal System

Part 3. Proposed Site Layout and Design Basis

No. of Bedrooms:	_____	
Design Flow:	_____	gal/day
Septic Tank Capacity:	_____	gallons
Percolation Rate:	_____	min/in
Length of Absorption Field:	_____	ft
Method of Garbage Disposal:	_____	
Size of Lot:	_____	sq ft
Separation Distance of System:		
<u>From all wells</u> , (including any on adjoining properties if within 200'):	_____	ft
<u>From any streams</u> , ponds, lakes or watercourse:	_____	ft

Please include diagram of proposed sewage disposal system sited on the property with all pertinent information, including:

- _____ Direction of surface drainage or contours.
- _____ Location of test holes.
- _____ Location of perc. tests.
- _____ Location of any wells within 200' of proposed system.
- _____ Location of any existing streams, watercourses, etc.

(Signature of Applicant)

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

EMPLOYER'S APPLICATION FOR CERTIFICATE OF COMPLIANCE WITH DISABILITY BENEFITS LAW

INSTRUCTIONS TO EMPLOYER: Complete PART I ONLY and have your Disability Benefits Insurance Carrier complete PART II.

PART I. TO BE COMPLETED BY EMPLOYER

EMPLOYER'S NAME AND ADDRESS (Home or Main Office)	LOCATION OF OPERATIONS
NAME UNDER WHICH BUSINESS IS CONDUCTED, IF DIFFERENT FROM ABOVE	OPERATIONS TO BEGIN ON OR ABOUT:
DISABILITY BENEFITS CARRIER (If More Than One, List All)	NYS UNEMPLOYMENT INSURANCE EMPLOYER'S REGISTRATION NUMBER

Application is hereby made to the CARRIER for a Certificate of Compliance with the Disability Benefits Law.

Date Signed _____ By _____
(Signature of Owner, Partner, or Authorized Officer)

Telephone No. _____ Title _____

PART II. TO BE COMPLETED BY DISABILITY BENEFITS CARRIER

CERTIFICATE OF COMPLIANCE WITH DISABILITY BENEFITS LAW

This is to certify that the above-named employer is insured with _____
(Name of Carrier)
and that the policy covers:

*a. ALL of the EMPLOYER'S employees eligible under the New York Disability Benefits Law.

*b. ONLY the following class or classes of the EMPLOYER'S employees:

Date Signed _____ By _____
Signature of Carrier's Authorized Representative (Currently on File With D.B. Bureau)

Telephone No. _____ Title _____

***IMPORTANT:** If BOX "a" is CHECKED, this certificate is COMPLETE. Mail it directly to the employer.
If BOX "b" is CHECKED, this certificate is NOT COMPLETE for purposes of Section 220, subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Disability Benefits Bureau, 180 Livingston Street, Brooklyn, New York 11248-0005.

PART III. TO BE COMPLETED BY WORKERS' COMPENSATION BOARD (Only if Box "b" of Part II has been checked)

State of New York
WORKERS' COMPENSATION BOARD

There is on file with the Workers' Compensation Board, Certificates of Insurance indicating that the above-named employer has complied with the Disability Benefits Law with respect to all of his/ her employees.

DISABILITY BENEFITS BUREAU

Date _____ By _____

Telephone No. _____ Title _____

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

APPLICATION FOR CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

The undersigned Employer desires to obtain a Certificate of Workers' Compensation Insurance from the

Insurance Carrier: _____

as satisfactory proof required under the provisions of Section 57 of the Workers' Compensation Law, to be filed with

Name: _____
(Name of Bureau, Department, Corporation, Firm or Individual)

Address: _____

Locations of operations: _____

Date operations to begin: _____

Telephone No. _____ Signature _____
(Name of Employer) (Date)

NOTE: This application must be signed by the Employer if an individual, or if a copartnership by a member of the copartnership, or by an officer if a corporation.

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

This is to certify that _____

is insured with the _____

under Policy No. _____ covering the entire obligation of this employer for workers' compensation

under the New York Workers' Compensation Law with respect to the locations named in the foregoing application. The policy

term covers the period from _____ to _____.

If said policy is changed or cancelled during its term in such manner as to affect this Certificate, thirty (30) days written notice of such change or cancellation [ten (10) days written notice in the event of cancellation for non-payment of premiums] will be given to

(Name of Bureau, Department, Corporation, Firm or Individual)

(Address)

in accordance with whose requirements, this Certificate has been issued. Notice by registered or certified mail, return receipt requested, so addressed shall be sufficient compliance with this provision.

Carrier _____ By _____
(Signature) (Date)

Telephone No. _____ Title _____