Whatcom County Health Department
509 Girard Street
Bellingham, WA 98225
Telephone: 360-778-6000
Fax: 360-778-6001

ON-SITE SEWAGE SYSTEM (OSS) REPORT OF SYSTEM STATUS

Homeowners - please use the HROSS form

Date of Inspection _____ Tax Parcel # _____

Site Address _____ Property ID: _____

Space/Lot Number or Location (if multiple OSS) _____

Owner _____ Phone _____

Originals must be submitted to the Health Department. No photocopies – No faxes.
Incomplete evaluations will not be accepted. All spaces must be complete or marked N/A if not applicable.

OPERATIONAL STATUS:

Upon Arrival ☐ Satisfactory ☐ Maintenance Needed ☐ Failure

Upon Completion ☐ Satisfactory ☐ Maintenance Needed ☐ Failure

(If 'Maintenance Needed" is checked, describe type of maintenance needed / completed on page 4 (Maintenance Addendum)
If septic tank pumping is only maintenance needed, page 4 is not required.)

EVALUATION PERFORMED FOR: ☐ Routine Compliance ☐ Property Transfer

OSS SOURCE: ☐ Single Family ☐ Food Service – Name: _____
☐ Community ☐ Other (*type*) _____

OSS TYPE: *Check **One***

☐ Conventional Gravity	☐ Pump to Gravity Distribution	☐ Non-Pressurized Mound
☐ Pressure Distribution	☐ ATU w/ Drip Irrigation	☐ Sand Filter w/ Pressure Dist.
☐ Biofilter	☐ ATU to Gravity	☐ Sand Filter w/ Gravity
☐ Drip Irrigation (w/out ATU)	☐ ATU w/ Mound	☐ Sand Filter w/ Mound
☐ Mound	☐ ATU w/ Pressure Distribution	
☐ Other _____		

SEPTIC TANK PUMPING RECOMMENDED? ☐ No ☐ Yes

SEPTIC TANK PUMPING IS <u>ONLY</u> MAINTENANCE NEEDED? ☐ No ☐ Yes

If tank was pumped, date: _____ ***Pumper*:** _____

PERMIT STATUS: ☐ Valid WCHD permit with final approval

☐ Non-finaled permit (application approval only) – <u>OSS Drawing **Required**</u> (Must use 8 ½" x 11")

☐ No Permit on File – <u>OSS Drawing **Required**</u> (Must use 8 ½" x 11")

☐ Site sketch on file with WCHD (from a previous ROSS)

I certify that I have performed the required OSS evaluation on the above referenced property. The information submitted in this report is true and correct. Findings and determinations of this evaluation reflect conditions as they existed on the day the OSS was evaluated.

O&M Specialist Signature _____ Print _____ Date _____

Office Use Only:
Rec'd by: _____

Rec'd date _____

WHATCOM COUNTY HEALTH DEPARTMENT
ON-SITE SEWAGE SYSTEM
REPORT OF SYSTEM STATUS CHECKLIST

509 Girard Street
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Date of Inspection _____ Tax Parcel # _____

Septic Tank

Tank Material ..... ☐ Concrete ..... ☐ Plastic ..... ☐ Metal ..... ☐ Wood ..... ☐ Other _____

Volume _____ Gallons .....# of Compartments _____

Depth of scum .....1st compartment _____ inches.....2nd compartment _____ inches

Depth of sludge .....1st compartment _____ inches.....2nd compartment _____ inches

Inlet baffle condition..... ☐ Satisfactory ..... ☐ Needs Repair

Outlet baffle condition..... ☐ Satisfactory ..... ☐ Needs Repair

Outlet Filter..... ☐ Satisfactory..... ☐ Needs Repair ..... ☐ Not Present ..... ☐ Cleaned

Watertight..... ☐ Yes..... ☐ No

Risers/Lids in good condition, lids secure & watertight .... ☐ Satisfactory ..... ☐ Needs Repair..... ☐ Not Present

Comments _____

Pump Tank..... ☐ N/A

Tank Material ..... ☐ Concrete ..... ☐ Plastic ..... ☐ Metal ..... ☐ Wood ..... ☐ Other _____

Volume _____ Gallons

Vault Screen ☐ Satisfactory..... ☐ Needs Repair ..... ☐ Not Present ..... ☐ Cleaned

Watertight..... ☐ Yes..... ☐ No

Risers/Lids in good condition, lids secure & watertight .... ☐ Satisfactory ..... ☐ Needs Repair..... ☐ Not Present

Depth of scum _____ inches……Depth of sludge _____ inches

Comments _____

Control Panel/Floats..... ☐ N/A..... Brand _____

Floats/transducer functioning properly ..... ☐ Yes..... ☐ No

Alarm working satisfactorily…… ..... ☐ Yes..... ☐ No

Pump controlled by ..... ☐ Dose timer..... ☐ Demand

Pump draw down _____ inches/minute

Timer settings… ._____ min. on…….. _____ hours off (timed) **OR** _____ gallons/dose (demand)

Adjustment needed..... ☐ Yes..... ☐ No

Comments _____

Aerobic Treatment Unit ..... ☐ N/A..... Brand _____

Air supply working ..... ☐ Satisfactory ..... ☐ Needs Repair

Alarm operation ..... ☐ Satisfactory ..... ☐ Needs Repair

Solids Levels ..... ☐ Satisfactory ..... ☐ Needs Pumping

Risers/Lids in good condition, lids secure & watertight ..... ☐ Satisfactory ..... ☐ Needs Repair

Comments _____

Disinfection Unit..... ☐ N/A..... Brand _____

Unit working as expected..... ☐ Yes..... ☐ No

Chlorine tablets in place ..... ☐ Yes..... ☐ No..... ☐ N/A

UV bulb replaced..... ☐ Yes..... ☐ No..... ☐ N/A

Comments _____

Media Filter ..... ☐ N/A

Type: ..... ☐ Sand Filter ..... ☐ Recirculating gravel ..... ☐ Textile ..... ☐ Other _____

Equal Distribution ..... ☐ Yes ..... ☐ No ..... ☐ N/A

Laterals flushed (individually) ..... ☐ Yes ..... ☐ No

Grading and cover ..... ☐ Satisfactory ..... ☐ Needs Repair

Abnormal ponding in filter ..... ☐ Yes *(explain in comments)* ..... ☐ No

Pump basin installed in sand or gravel filter (use add'l tank addendum) ... ☐ Yes ..... ☐ No

Comments _____

Drainfield

☐ Gravity ☐ Pressure Type: ☐ Trench……☐ Bed ..... ☐ Gravel ..... ☐ Gravelless/Chamber

Graded properly for surface water runoff ..... ☐ Yes ..... ☐ No

Downspouts diverted away from drainfield ..... ☐ Yes ..... ☐ No

Curtain Drain Functioning ..... ☐ Yes ..... ☐ No ..... ☐ N/A

Evidence of compaction over drainfield ..... ☐ Yes ..... ☐ No

Encroachment from buildings etc ..... ☐ Yes ..... ☐ No

Vegetative cover properly managed ..... ☐ Yes ..... ☐ No

Monitoring ports ..... ☐ Satisfactory ..... ☐ Needs Repair ..... ☐ N/A

Abnormal ponding or erosion ..... ☐ Yes……☐ No

Comments _____

Distribution box....Surface access... ☐ Yes ..... ☐ No ..... Equal distribution ... ☐ Yes ..... ☐ No

Laterals flushed *(pressurized only)* ..... ☐ Yes ..... ☐ No

All laterals have equal flow and residual pressure *(pressurized only)* ..... ☐ Yes ..... ☐ No

Squirt height measurement at distal end of each lateral (pressurized only) _____ **"**

Diversion valve switched ..... ☐ Yes ..... ☐ No ..... ☐ N/A

Comments _____

Drainfield Flow Test ..... **Total Number of Bedrooms Served by OSS:** _____

Ran test for _____ minutes; approximately _____ gallons ran through system

Level in septic tank at start of test _____ **"** .....Level at end of test _____ **"** .....Returned to normal in _____ minutes

Pump systems - float tether length _____ **"** Number of pump cycles run _____

Evidence of dye and/or effluent surfacing ..... ☐ Yes ..... ☐ No

Comments _____

Mounds (including Glendon BioFilters) .....☐ N/A ..... ☐ Gravity ..... ☐ Pressure ..... ☐ Proprietary

Seepage around toe of mound observed ..... ☐ Yes ..... ☐ No

Structural integrity and ground cover ok ..... ☐ Yes ..... ☐ No

Comments _____

Subsurface Drip System .....☐ N/A

Dosing frequency _____ times daily ....System return pressure _____ PSI

Consistent with baseline... ..... ☐ Yes ..... ☐ No

Automatic flushing operating satisfactorily ..... ☐ Yes ..... ☐ No ..... ☐ N/A

Vacuum breakers operating properly ..... ☐ Yes ..... ☐ No

Grading and cover …… .... ☐ Satisfactory ..... ☐ Needs repair

Comments _____

Whatcom County Health Department

ON-SITE SEWAGE SYSTEM MAINTENANCE ADDENDUM

509 Girard Street
Bellingham, WA 98225
Telephone: 360-778-6000
Fax: 360-778-6001

Date of Maintenance _____ Tax Parcel # _____

Site Address _____ Property ID: _____

Owner _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Attention: *Complete* ***all*** *fields if submitted as a standalone document*

Type of maintenance needed ***(please print clearly and attach more pages or copies of invoices if necessary)*****:**

Type of maintenance completed. Please indicate if no maintenance completed ***(please print clearly and attach more pages or copies of invoices if necessary)*****:**

I certify that I have performed the OSS maintenance on the above referenced property. The information submitted above is true and correct.

_____ _____ _____

Signature Print Date

Mailing Address _____ Phone Number _____

City/State/Zip _____ Email _____