TOWN OF KILLINGWORTH
HEALTH DEPARTMENT
323 RT 81, Killingworth, CT 06419
PHONE: (860)663-1765 x223 FAX: (860)663-3305

Water Treatment Wastewater (WTW) Disposal System Application

Date: _____

Property address: _____ Owner: _____

WTW Installer: _____ Installer Address: _____

Installer Phone Number: _____ Installer Signature: _____

Please provide/submit the following:

- Type of water treatment device_____
- Manufacturer_____
- Model #_____
- Waste water discharge volume per cycle_____
- Waste water discharge cycle frequency_____
- Purpose of water treatment device (what is being removed?)_____
- Proposed waste water disposal method: leaching unit _____ connection to septic tank _____ holding tank _____
- Include a design plan/sketch of the proposed disposal method. Include as appropriate type of leaching system, size, length, piping, size of holding tank.
- If proposed leaching system: depth to ledge _____ and depth to maximum ground water_____
- Distance to closest well_____
- Distance to closest septic system_____

All applicable permits (electrical, plumbing, etc.) must be obtained from Building Official

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Office use only:

Reviewed by: _____

Approval Signature: _____ Date of Approval: _____

Application Fee **$75.00** Payment Date: _____

Payment: Cash or Check No. _____ Receipt No.: _____

Notes: