Revised 03-17-2023

Parke County Health Dept.

116 W. High St., Room 12
Rockville, IN 47872
Phone (765) 569-4071
Fax (765) 569-4061

APPLICATION FOR ONSITE SEWAGE SYSTEM PERMIT

____ Residential ($75.00) ____ Commercial ($100.00)
Please complete Credit/Debit Card Payment Authorization Form (attached) for payment by credit/debit card.

Please complete the information on this page:

Owner's Name _____Phone _____

Owner's mailing address _____

City _____ State_____ Zip Code _____

E-mail Address_____

Site Address: _____

City _____ State_____ Zip Code_____

DIRECTIONS to site:

_____

_____

Nearest crossroads: _____Distance to property_____
Nearest mailbox number: _____Distance to property_____
Landmarks noticeable from road (i.e. buildings, ponds, etc.) _____

We will need a copy of the deed.

Water supply: _____City_____County _____ Well _____Spring _____Other

Number of bedrooms _____ Number of bathrooms _____ Number of people in house _____

Number of jetted bathtubs (whirlpool-type 125 Gal & over) _____ Est. Sq. Footage of House _____

Name, address, phone# of installer_____

Name, address, phone# of builder _____

Non-refundable application fee is required before a permit can be issued. This is an application only, not a permit.
I have read this application and hereby certify that, to the best of my knowledge, the information on this sheet is correct. In addition, the water supply and sewage facilities for this building will be installed strictly in accordance with all provisions of Indiana State Law 410 IAC 6-8.3, and with the Parke County Sewage Disposal Ordinance. I will allow Parke County Health Department personnel onto the property at any time for inspections of the septic system.

A permit may be revoked by the Parke County Health Department for failure to comply with Indiana State Department of Health Rule 410 IAC 6-8.3 and/or any other applicable regulations. (Revocation of the permit shall be in writing to the property owner and/or their agent; shall state the reasons for revoking the permit; remedial actions necessary; and upon written request afford the applicant the opportunity for a fair hearing.)

Applicant's Signature _____ Date _____

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Credit/Debit Card Payment Authorization Form

The completion and signing of this form authorizes the Parke County Health Department use of the credit/debit card information listed below. The Parke County Health Department also has permission to debit the account for any fees due to applicant, including a Convenience Fee of $1.00 + 1.99%. Please complete fully.

I, _____**[printed name]** authorize the Parke County Health Department to charge my credit/debit card account in an amount due for licenses, permits, or vital record searches and/or certificates on or after_____**[date].**

Signature _____

I authorize the above named to charge the credit/debit card indicated in this authorization form according to the terms outlined above. This authorization is limited to one use. I certify that I am an authorized user of the afore mentioned card. I will not dispute the payment with the credit card company; so long as the transaction corresponds to the terms indicated in this form.

Name: _____

Billing Address: _____ Phone: _____

City, State, Zip: _____ Email: _____

Office Use Only

OTC Local Reference ID #: _____ Initials: _____ Date: _____

Please Fill Out Card Information

Account Type (Choose One): [ ] Visa [ ] MasterCard [ ] Discover

Account Number: _____ Expiration Date: _____

Security Code (3 Digit): _____