



EVALUATION CHECKLIST USE PRIOR TO REPAIRING ONSITE SYSTEM

NAME _____ PHONE _____

SITE ADDRESS _____ PHONE _____

_____ PHONE _____

MAILING ADDRESS (If Different) _____

DATE _____ Sun Mon Tue Wed Thur Fri Sat TIME OF DAY _____

1. # OF PEOPLE LIVING IN HOME: ADULTS: _____ M _____ F CHILDREN (Total inc. Teenagers)
TEENAGERS: _____ M _____ F

2. LAUNDRY HABITS: MAX. _____ LOADS / DAY CONSECUTIVE LOADS: YES / NO
TOTAL _____ LOADS/WEEK

3. BRAND OF LAUNDRY DETERGENTS USED: _____ WITH / WITHOUT BLEACH POWDER / LIQUID

4. BLEACH USED: YES / NO POWDER / LIQUID USE: _____ CUPS/LOAD _____ LOADS/WEEK

5. HOT OR COLD WATER USED: _____

6. LIQUID FABRIC SOFTNER USED: _____

7. NUMBER OF ROLLS OF TOILET PAPER USED PER WEEK: _____

8. GARBAGE DISPOSAL: YES / NO USE: _____ TIMES/DAY _____ TIMES/WEEK

9. DISHWASHER: YES / NO USE: _____ TIMES/DAY _____ TIMES/WEEK

10. IS A WATER SOFTENER USED: YES / NO SALINE CHLORINATION: YES / NO

11. IS A DRAIN CLEANER USED: YES / NO BRAND _____ FREQUENCY: _____

12. LIST ANY ANTIBACTERIAL PRODUCTS USED (ie: hand cleaner, soaps, cleaning products): _____

13. IS ANY RESIDENT USING A (LONG TERM) PRESCRIPTION DRUG OR ANTIBIOTICS: YES / NO

14. IS THIS THE FIRST HOME YOU HAVE LIVED IN THAT HAS A SEPTIC SYSTEM: YES / NO

15. HOW OLD IS THE SYSTEM: _____ YEARS

16. HAS THE SYSTEM EVER BACKED UP: YES / NO DAY OF WEEK: _____ Sun Mon Tue Wed Thurs Fri Sat

17. HAS EFFLUENT EVER SURFACED: YES / NO
IF YES: WINTER: YES / NO SUMMER: YES / NO DAY OF WEEK: _____ Sun Mon Tue Wed Thurs Fri Sat

18. HAS PLUMBING EVER BACKED UP INTO HOME: YES / NO
IF YES: WINTER: YES / NO SUMMER: YES / NO DAY OF WEEK: _____ Sun Mon Tue Wed Thurs Fri Sat

19. WATER SOURCE: (circle) PUBLIC PRIVATE WELL COMMUNITY WELL OTHER _____

20. TYPE OF SYSTEM: GRAVITY / GRAVITY WITH PUMP / PD / MOUND / SAND FILTER / ATU OTHER _____

21. CONTROL SYSTEM: DEMAND / TIMED

22. SCREENED OUTLET BAFFLE: YES / NO HAS SCREEN EVER PLUGGED: YES / NO

23. DATE OF LAST PUMPOUT: _____

24. SLUDGE LEVELS IN SEPTIC TANK: 1ST COMPARTMENT ACCUM. _____" FLOATING MAT _____"
2ND COMPARTMENT ACCUM. _____" FLOATING MAT _____"

25. SLUDGE LEVEL IN PUMP TANK: ACCUM. _____"

26. FLOWS: _____ GPD (Design) _____ GPD (Average) _____ GPD (Peak)

27. SOIL TYPE WITHIN BOTH 12" HORIZONTAL AND 12" BELOW THE BOTTOM OF THE DISPOSAL FIELD:
_____ 1 2 3 4 5 6 (circle) _____ OR _____ MPI (perc rate)

28. WATER TABLE: (use same soil log hole used above) DEPTH: (measured from bottom of hole) _____

29. MOTTLING: DEPTH (measured from bottom of disposal system) _____

30. DRAINFIELD: DEPTH (measured from bottom of disposal system) _____

31. DEPTH OF SLUDGE: (if present, measured from bottom of disposal system) _____

32. DRAINFIELD FLOODED: YES / NO IF YES: # OF LINES FLOODED _____

33. IS SYSTEM CURRENTLY SURFACING: YES / NO LOCATION : (circle) _____ Septic Tank / Pump Tank / Sand Filter /
Mound / Drainfield / ATU / Other

34. WASTE CHARACTERISTICS: TEMP _____ DO _____ pH _____

35. WASTE STRENGTHS: BOD₅ _____ TSS _____ FOG _____

36. DETAILS OF WHERE AND HOW SAMPLES WERE COLLECTED: _____

With a completed checklist, we are able to evaluate whether or not you are using your onsite system in a manor that may shorten the life of your system. We will send you a report and, if indicated, suggest changes that should be made in order to keep the system operating properly. Should your information indicate the system may be in a pre-failing or failing state, for an additional fee we can perform a further in-depth evaluation including recommendations.

If you would like Aqua Test to review a completed checklist for you, please fill out the form and mail, along with a check for \$50, to Aqua Test, Inc., PO Box 1116, Black Diamond, WA 98010.