HEALTH DEPARTMENT

APPLICATION FOR PRELIMINARY SUBDIVISION APPROVAL

NAME OF SUBDIVISION: _____

NUMBER OF LOTS: _____ TOTAL ACRES: _____

ROAD: _____

DIRECTIONS TO PROPERTY:

OWNER OF PROPERTY: _____
MAILING ADDRESS:

_____
CITY: _____ STATE: _____ ZIP: _____

CONTACT PERSON / DEVELOPER: _____

Office phone:_____ Home Phone:_____
Cellular phone:_____ E-MAIL
ADDRESS:_____

PROPERTY INFORMATION:

NUMBER OF EXISITING HOMES: _____
Lot Number: _____ Number of Bedrooms: _____ Year Built: _____
Lot Number: _____ Number of Bedrooms: _____ Year Built: _____
Lot Number: _____ Number of Bedrooms: _____ Year Built: _____

WATER SUPPLY: WELL: ☐ UTILITY: ☐
PUBLIC SEWAGE SYSTEM: ACCESSIBLE: YES ☐ NO ☐

REVIEW REQUIREMENTS FOR MAPS

1. Is a High Intensity Soil Map with property boundaries attached ? ☐ Yes ☐ No
   (2 copies required)

NOTE: Soil information is required on all lots that are shown on survey regardless of size.

2. Are all maps on the scale of 1" = 100' ? ☐ Yes ☐ No

3. Does the boundary survey have a location map ? ☐ Yes ☐ No

4. Does the boundary survey have a accuracy statement ? ☐ Yes ☐ No

5. Does the boundary survey have surveyor's seal and signature ? ☐ Yes ☐ No

6. Does the boundary survey have a North arrow ? ☐ Yes ☐ No

7. Are existing homes shown on boundary survey ? ☐ Yes ☐ No

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

TO BE COMPLETED BY THE HEALTH DEPARTMENT

DATE: _____ AMOUNT PAID: _____

RECEIPT NUMBER: _____