northern health
the northern way of caring

WATER SYSTEM APPLICATION FOR CISTERNS

PLEASE PRINT CLEARLY | **SHADED AREAS TO BE COMPLETED BY DWO**

Date of Application:	Date of Opening:	☐ New Premise
Legal Name of Business:		☐ Owner Change
Owner's Name		☐ Other Change
Business Phone:	Cell:	Details:

Home:	Fax:	Email:

Type of Business: ☐ Sole Proprietorship ☐ Corporation ☐ Partnership ☐ Utility ☐ Society ☐ Other

Common Name of Water System:

Physical Location Street Address, Municipality (City, Regional District, etc)

Directions to Water System if Remote:

Mailing Address:

Contact Person (if different from owner)		Position:
Contact Person Phone:	Fax:	Cell:
Contact person Email:		

Water System	Permit: ☐ Yes ☐ No ☐ Pending
Type: ☐ Cistern (Other, Hauled Water)	Category: ☐ WS1 ☐ WS2 ☐ WS3 ☐ WS4
More than one source for this water? ☐ Yes ☐ No	Permit Conditions Attached: ☐ Yes ☐ No
List source(s) of hauled water:	Emergency Response Plan Status: ☐ Needs Review ☐ Accepted
Name of Water Hauler:	☐ Unaccepted Date of Acceptance:________________
Emergency Response Plan Submitted: ☐ Yes ☐ No If No, expected date _________________________	Date of Review:____________________ Date of Next Review:________________

EOCP/Water Safe Certified? : ☐ Yes ☐ No Note: Environmental Operators Certificate Program	Operator Certificate # If No, expected date of certification:	Water System Certificate #:
Will system operate ☐ Year Round ☐ Seasonal	If Seasonal, list months of operation:	

Signature of Applicant	Date:
Print Name:	
Approved by DWO/EHO:	Date:
Assigned EHO's name	Processed by (admin support)
Comments:	

Storage: CISTERN	Construction Date:
Construction Material: ☐Concrete ☐Fiberglass ☐Aluminum ☐Stainless Steel ☐ Epoxy Coated Steel	
Type: ☐Elevated Tank ☐Ground Level ☐Underground	
Volume:	Turnover time:
Security: ☐Hatch is sealed ☐Hatch is locked ☐Security Fencing ☐Gate locked ☐Alarmed ☐Covered ☐Enclosed ☐Vents are Screened	
Water Level Indicator ☐Yes ☐No	Treated: ☐Yes ☐No
Operation and Maintenance ☐Inspection Schedule ☐Water Quality monitoring ☐Security Checks ☐Cleaning and Disinfection Schedule ☐FAC Residual Monitoring	
Chlorine Test Kit Name of Kit: Free Chlorine Range :	
Log Book kept on site: ☐Yes ☐No	

Distribution:	EOCP # EOCP Classification
Number of Connections: Population Served:	
Cross Connection Control Program: ☐Yes ☐No	Flushing Program: ☐Yes ☐No

List the mailing address where you wish to receive your water requisitions:

Water Sampling Sites: TO BE FILLED OUT BY EHO
Site Name: Kitchen Tap Site Address:
Site Source: Other/ Cistern
Source Type: Distribution Treated Water: ☐Yes ☐No
Regular Sampler: Water Operator Sampler Name:
Sampler Address:
Sampling Type: Bacteriological Sampling Reason: **Monitoring**
Bacteriological Sampling Frequency: ☐Weekly ☐Bi-Weekly ☐Monthly
Sampling Months: Jan Feb March April May June July August Sept Oct Nov Dec
Sample Reports: ☐All ☐Positive Only ☐None Email:

Water Sampling Sites: TO BE FILLED OUT BY EHO
Site Name: Audit Site Address:
Site Source: Other/ Cistern
Source Type: Distribution Treated Water: ☐Yes ☐No
Regular Sampler: EHO Sampler Name:
Sampler Address:
Sampling Type: Bacteriological Sampling Reason: **AUDIT**
Bacteriological Sampling Frequency: No Regular Sampling