## SEWER SERVICE CERTIFICATE - FOR SUBDIVISIONS

**PLEASE ALLOW A MINIMUM OF 2 FULL BUSINESS DAYS FOR PROCESSING**

### TO BE FILLED OUT BY APPLICANT

1. Project Number: __________________________________________________________

   **TRACT MAP, PARCEL MAP, PARCEL MAP WAIVER**

2. Total number of sewer service connections: ___________________ + __________________

   existing proposed

3. Assessor's Parcel Number: ___ ___ ___ - ___ - ___ ___ ___ - ___ ___ ___

4. Owner's/Applicant's Name: __________________________________________________

5. Mailing Address:

   ______________________________________________________________

   Street City Zip

6. Telephone: ______________________________________________________________

### TO BE FILLED OUT BY SANITARY DISTRICT

Date: _________________________________

The: __________________________________

Sanitary District

received a request to provide public sewer service to the total number of connections identified above.

This letter is to certify that:

1. a. A binding agreement has been entered into between the owner of the land and the public sewer entity, enforceable by the owner and the owner's successors in interest to the land, providing, on terms substantially the same as those given the public sewer entity's customers generally, for the connection to the public sewer entity's system of each lot proposed to be served by the public sewer entity.

   OR

b. Each lot proposed to be served by the public sewer entity will be served through an existing connection provided by the public sewer entity to the property.

2. The portion of the improvement plans containing the design and specifications for subdivision sewer is satisfactory to the public sewer entity.

By: ____________________________________________________________

DESIGNATED SANITARY DISTRICT REPRESENTATIVE TITLE

### FOR OFFICE USE ONLY

Received by: ____________________________

Date Recd.: ____________________________

Amr. Recd.: ____________________________

Receipt No.: ____________________________

Check No.: ____________________________

Approved _____ Denied _____

Date: ____________________________

EHD Specialist ____________________________

**DISTRIBUTION:** 1. EHD  2. RMA Planning  3. Applicant