



Delaware General Health District

Environmental Health Division

1 West Winter Street, 2nd Floor, P.O Box 570, Delaware, Ohio 43015 Phone: (740) 368-1720 Fax: (740) 368-1736

Soil Evaluation Application

Person requesting Soil Evaluation _____ Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

Owner of Property (if different) _____ Phone # _____

Mailing Address _____ City _____ State _____ Zip _____

We cannot schedule the soil evaluation until we have a site plan and the property lines have been identified and clearly marked. Please ensure that the site has been prepared accordingly before the soil evaluation is conducted. Failure to do so may result in an incomplete evaluation.

The soil evaluation can be done by a private soil evaluator OR the Delaware General Health District. A soil evaluation with a minimum of two test holes is required for each lot. The Delaware General Health District requires excavated test pits. This requires the applicant to provide a backhoe and backhoe operator. Test pits shall be dug 5' deep by 3' wide with safe egress sloped sides. It is the applicants' responsibility to contact the entity of their choice to provide the desired service. If the Health District is desired for a soil evaluation, the backhoe operator shall contact the Delaware General Health District to schedule the soil evaluation. The applicant and/or property owner are responsible for any fees associated with soil scientists or backhoe work. It is required that the Ohio Utility Protection Service (OUPS) be contacted to mark all underground services prior to digging. 1-888-258-0808

I have read and understand the above statement and request the Delaware General Health District conduct a soil evaluation on the applicable property.

Owner Signature _____ Date _____

Requester Signature _____ Date _____

Site Location _____

Township _____ Size (acres) _____ Proposed # Bedrooms _____ Lot # _____

Parcel # _____ Subdivision _____

Excavation Company _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Office Use Only

Sanitarian _____ Date _____ Time _____ Receipt # _____

Site # _____ NPA # _____