



**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH
PUBLIC WATER SYSTEM SCREENING FORM**
Pursuant to CGS Sections 16-262m & 8-25a and RCSA Section 19-13-B102

Section 1: Basic Information

Project Type: Conversion of Existing Structure/Property Proposed Development
 Unclassified Facility Currently in Operation PWS Classification Review (Change in Use)
 Change of Ownership (PWS Responsibilities letter will be sent out)

Anticipated Start Date: _____

Name of Facility			Maximum Daily Population Served		Customer of a water company? <input type="checkbox"/> Yes <input type="checkbox"/> No
PWS ID #			Current: Proposed:		
Property Address			Number of Service Connections:		Proposed/current daycare capacity: NA
City	State	ZIP Code	Residential	Non-Res	

Number of days per year facility is/will be operational: _____

Description of Project (Attach additional pages if necessary, please see instructions for additional information):

Section 2: Facility Information

Type of Facilities (Check all that apply) Residential School Food Service Day Care Campground
 Medical/Dental Professional Office Youth Camp Gas Station Retail Manufacturing Place of Worship
 Park/Recreation Area Other - specify: _____

Will or does the facility supply water for human consumption to its employees, students, customers, visitors and/or members?: Yes No

Type of water use at the facility (check all that apply):
 drinking bathing/showering cooking dishwashing public restroom drinking water fountain
 other: _____

Will or do at least 25 persons (including employees, customers, parishioners, visitors, etc. but not necessarily the same persons) visit the facilities/businesses supplied by the water system daily at least 60 days out of the year (days do not need to be consecutive days)? Yes No

Facility annual operating period (begin/end dates of operation): From _____ (month/day) to _____ (month/day)

Number of same persons (i.e. employees, students, but not residents) that will or do regularly use the facility on a daily basis for at least six months a year: _____

Number of persons whose primary residence is or will be supplied by the facility based on design population: _____

Does this water system have any treatment? Yes No
 If yes, specify type: _____ Purpose: _____

Section 3: Property Owner Contact Information

Name		Legal Contact Person (if owner is not an individual)		
Mailing Address		City	State	ZIP Code
Telephone	Fax	Emergency Phone		
E-mail Address				

Section 4: Certification Statement

I certify to the best of my knowledge that the information provided in this application is complete and correct. I understand that the information I provide will be used by the Department of Public Health, Drinking Water Section to determine if a proposed project or existing facility will be or is considered a water company and a public water system and to also determine the most appropriate steps for initiating the regulatory process.

Signature of Property Owner/Legal Contact: _____ Date: _____

Printed Name of Property Owner/Legal Contact: _____

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Section 5: Local Health Department Review

Please provide any additional information you believe would be helpful for DWS staff to evaluate this form. Examples of additional information include any previous property names/ PWSID the water system may have been regulated under, whether the property is part of a plaza with other uses and what those other uses might be, etc:

Local health understanding of water use at the facility:

- drinking bathing/showering cooking dishwashing public restroom drinking water fountain
- other: _____

Is the information provided by the applicant in Section 1 and 2 of this form consistent with your understanding of the current/proposed use of the property? Yes No

Signature of Local Director of Health or Registered Sanitarian

Date

Printed Name of Local Director of Health or Registered Sanitarian

FOR DWS USE ONLY

CPCN: Yes No

Reactivation of former PWS: Yes No

New Water System (currently in operation): Yes No

PWS Classification Review: Yes No

Change of Ownership (send PWS responsibilities letter) Yes No

System Classification: C NTNC TNC NP Date of determination: _____ DWS Project #: _____

Please submit completed forms and all Supporting Documents to:

DWDCCompliance@ct.gov

or

Department of Public Health
Drinking Water Section
410 Capitol Avenue, MS#12DWS
P.O. Box 340308
Hartford, CT 06134-0308