



**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:		<input type="checkbox"/> Conversion of Existing Structure/Property <input type="checkbox"/> Unclassified Facility Currently in Operation <input type="checkbox"/> Change of Ownership (PWS Responsibilities letter will be sent out)		<input type="checkbox"/> Proposed Development <input type="checkbox"/> PWS Classification Review (Change in Use)	
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	
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: eric anderson Date: _____

Printed Name of Property Owner/Legal Contact: _____

For Local Health Use Only**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:

DWDCompliance@ct.gov

or

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