



Joseph P. Ganim
Mayor

City of Bridgeport

Department of Health & Social Services Environmental Health

999 Broad Street, Bridgeport, CT 06604
Telephone: (203) 576-7474
Fax: (203) 576-7793
Bridgeportct.gov/EnvironmentalHealth

Dr. Elizabeth Rivera-Rodriguez,
DNP, MPH, MSN, RN
Director of Health
& Social Services

Sumit Sharma, MPH, MDiv.
Deputy Director of Health
& Social Services

PERMIT TO DISCHARGE

Approval is hereby given to _____, in accordance with Public Health Code
(Property Owner)

19-13-B103e (h) to discharge to a subsurface sewage disposal system located at

(Street Address)

in the town of Bridgeport, Connecticut that will receive domestic sewage from a:

Residential building containing _____ bedrooms. Single family (Y/N): _____

Restaurant containing _____ seats.

Commercial/Office building providing _____ square feet.

Other structure as described: _____

Design Flow = _____ gallons per day. **Permitted Flow** = _____ gallons per day. The design flow shall equal the permitted flow, except for non-compliant repairs (See Section IV D).

In order to provide a sufficient factor of safety it is recommended that the average daily discharge not exceed 2/3 of the permitted flow or _____ gallons per day.

Operation and Maintenance: Septic tank shall be inspected regularly and pumped as needed but not less frequently than every five years. The septic tank has an effluent filter (Y/N) _____. Effluent filters require periodic cleaning. Failure to clean filters can result in sewage backup into the building or effluent breakout. Restaurants serviced by external grease interceptor tank(s) require quarterly inspections and cleaning as necessary. Tank pump-outs tracked by local health department (Y/N) _____. If yes, stipulate pump-out requirements: _____

Special Requirements and Restrictions: _____

Exceptions (Repairs Only): _____

File Information: Construction Permit No. _____. Approved as built on file (Y/N) _____

Date of Final Inspection: _____ Inspected By: _____

Permit Issuance: Issued by: _____ **Title:** _____
(Director of Health or Registered Sanitarian)

Signature: _____ Date: _____

Permit expiration date (5 years from issuance date): _____