



Health and Sanitation Department  
*TOWN OF NEW FAIRFIELD*  
4 Brush Hill Road  
New Fairfield, CT 06812-2665  
(203) 312-5640 (203) 312-5608  
health@NewFairfield.org

OFFICE USE ONLY	
Date Paid:	_____
Check #:	_____
Date of Test:	_____

## Application for Soil Testing

**\$100 Soil Test Fee** (per lot). Make checks payable to: **Town of New Fairfield**

This form must be completed and submitted with payment before soil testing will be scheduled.

\_\_\_\_\_  
Street Address of Testing

\_\_\_\_\_  
Map

\_\_\_\_\_  
Block

\_\_\_\_\_  
Lot

\_\_\_\_\_  
Owner's Name

\_\_\_\_\_  
Owner's Phone

\_\_\_\_\_  
Owner's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Septic Installer's Name

\_\_\_\_\_  
Septic Installer's Phone

\_\_\_\_\_  
License #

\_\_\_\_\_  
Septic Installer's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Engineer's Name

\_\_\_\_\_  
Engineer's Phone

\_\_\_\_\_  
License #

\_\_\_\_\_  
Engineer's Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

**Contact Phone Number to schedule soil testing:** \_\_\_\_\_

**Reason for soil testing:**

New Construction

Septic Repair

B-100a Reserve

\_\_\_\_\_  
**Signature of Applicant (Owner or Authorized Agent)**

\_\_\_\_\_  
**Date**