

Commonwealth of Massachusetts

HAMILTON BOARD OF HEALTH
577 Bay Rd., P.O. Box 429
Hamilton, MA 01936

System Pumping Record

System Owner _____ System Location _____

Property ID (Assessor's Map) _____ Lot # _____

Date of Pumping: _____ Quantity Pumped: _____

Emergency: _____ Routine: _____

Cesspool: Yes _____ No _____ Septic Tank: Yes _____ No _____

Failed System: Yes _____ No _____

Note: All Cesspools MUST be pumped

System Pumped By: _____

Permit # _____

Contents Transferred To: _____ Other: _____ Date: _____

*Condition of Cesspool: _____ Septic Tank: _____ Tight Tank: _____

Breakout or Ponding: Yes ___ No ___ Breakout or Ponding: Yes ___ No ___ Breakout or Leaking: Yes ___ No ___

Cesspool Structure: Yes ___ No ___ Tank Structure: Yes ___ No ___ Tank Structure: Yes ___ No ___

Liquid Levels above inlet invert: Yes ___ No ___ Liquid Levels above outlet invert: Yes ___ No ___

Tees or baffles missing or broken: Yes ___ No ___

Is there an effluent filter? Yes ___ No ___ Was it Cleaned ___ Replaced ___ In what condition is it? _____

*If Yes is checked on any of the above items please describe the problem(s) you have seen:

Pumper/Inspector: _____
Signature _____ Print Name _____