



MONTAGUE BOARD OF HEALTH

One Avenue A · Turners Falls, MA 01376

TELEPHONE 413-863-3200 EXT 205 · FAX 413-863-3225

GINA MCNEELY, R.S.
DIRECTOR OF PUBLIC HEALTH

APPLICATION FOR WELL CONSTRUCTION / DESTRUCTION PERMIT

DATE _____ FEE PAID \$ _____

NAME OF APPLICANT _____ PHONE # _____

ADDRESS OF APPLICANT _____

LOCATION OF PROPERTY _____

SIZE OF LOT (acres or square feet) _____ ASSESSOR'S MAP & LOT _____

NAME OF PROPERTY OWNER _____ PHONE # _____

NAME & LICENSE # OF WELL DRILLER _____

MAILING ADDRESS OF WELL DRILLER _____

____ NEW CONSTRUCTION
NEW DWELLING

____ NEW CONSTRUCTION
OLD DWELLING

____ REPAIR OF EXISTING
WATER SUPPLY SYSTEM

____ DESTRUCTION OR
ABANDONMENT OF AN EXISTING WELL

IS THERE A RESIDENCE WITHIN 200' OF THE WELL? _____

SEE SECTION 1.6 AND 1.7 OF THE MONTAGUE WELL REGULATIONS (attached to this application) AND SUPPLY A PLOT PLAN WHICH CLEARLY SHOWS ALL THE REQUIRED SETBACKS.

PLOT PLAN SHALL SHOW THE FOLLOWING WITHIN 200 FOOT RADIUS OF THE PROPOSED WELL:

- EXISTING OR PROPOSED STRUCTURES
- SURFACE WATERS AND SURFACE DRAINAGE COURSES
- SUBSURFACE SEWAGE DISPOSAL SYSTEM (THE ENTIRE SYSTEM)
- SUBSURFACE FUEL STORAGE TANKS
- ANY POTENTIAL SOURCES OF CONTAMINATION
- PROPERTY LINES
- PUBLIC WAYS
- TOPOGRAPHY OF SITE (WELL SHOULD BE LOCATED AT A HIGHER ELEVATION THAN THE SEPTIC SYSTEM AND ANY POTENTIAL SOURCES OF CONTAMINATION)

**You must turn this
page over and sign
this application.**



PLOT PLAN ATTACHED _____ YES _____ NO

NO PERMIT WILL BE ISSUED WITHOUT A SATISFACTORY PLOT PLAN ATTACHED.

By signing below the applicant acknowledges and understands that the Board of Health issues well drilling permits based on the information provided with this application and the accompanying plot plan. The Board of Health expects the site conditions and setbacks depicted in the plot plan are accurate and true. Placing a well in different location than depicted on the plan may invalidate the well.

Applicant signature _____ Date: _____

FOR BOARD OF HEALTH ONLY

APPLICATION APPROVED _____ DATE _____

APPLICATION DENIED _____ DATE _____

REASON FOR DENIAL _____

BOARD OF HEALTH MEMBER OR AGENT'S SIGNATURE

_____ DATE _____