City of Prescott Sewer Usage Questionnaire

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 1. **Facility Name:**

_____

* 2. **Facility Physical Address:**

Street: _____

City: _____

State: _____

Zip Code: _____

* 3. **Owner Mailing Address:**

Street: _____

City: _____

State: _____

Zip Code: _____

4. **Tenant Mailing Address (if applicable):**

Street: _____

City: _____

State: _____

Zip Code: _____

* 5. **Facility Phone Number (including area code):**

(XXX) XXX-XXXX

_____

* 6. **Person authorized to represent the facility with official dealings with the City of Prescott:**

Name: _____

Title: _____

Phone Number (including area code): (XXX) XXX-XXXX

_____

* 7. **Email address:**

_____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

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* 8. **What category below best describes the facility?**

○ Industrial/Manufacturing (Examples: electroplating, pharmaceuticals, paint & ink manufacturing, chemical manufacturing, iron & steel, mining)

○ Medical Services (Examples: hospitals, urgent cares, medical offices, dental offices, long-term care facilities, veterinary clinics/hospitals)

○ Food Services (Examples: restaurants, educational facilities, grocery stores, delis, coffee shops)

○ Vehicle Services (Examples: vehicle repair facilities, vehicle maintenance facilities, tire shops, car washes)

○ Waste Hauling

○ Dry Cleaning

○ None of the above

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* 9. **What type of waste(s) does the facility generate?**

(Check all that apply)

❑ Sanitary wastewater (i.e., restrooms, showers)

❑ Non-sanitary wastewater (i.e., discharges to the sewer that differ in quality or quantity from ordinary residential households)

❑ Waste containing metals

❑ Waste containing chemicals and/or solvents

❑ Medical waste

❑ Fats, oils, and/or greases (i.e., restaurants)

❑ Sand, grit, and/or gravel

❑ Detergents and/or cleaners

❑ Septage, RV waste, and/or other pumped waste

❑ Storwater run-off

❑ Facility or equipment washdown

❑ Other (please describe below):

_____

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* 10. **Where are waste(s) disposed of?**

(Check all that apply)

❑ Sanitary sewer

❑ Stormwater sewer

❑ Waste haulers

❑ Evaporation

❑ Other (please describe below):

_____

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* 11. **Does the facility have pretreatment devices or on-site treatment processes for wastewater? (i.e., grease trap, grease interceptor, oil/water separator, chemical precipitation)**

○ Unsure

○ No

○ Yes (please describe type, size and location):

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 12. **Indicate the type of facility:**

(Check all that apply)
❑ Hospital
❑ Urgent Care
❑ Medical Office
❑ Dental Office
❑ Long-Term Care
❑ Laboratory
❑ Veterinary Clinic
❑ Animal Hospital
❑ Other (please describe below):

_____

13. **Does the facility conduct medical imaging?**
○ Yes   ○ No

14. **How does the facility dispose of the following medical wastes:**

Sharps (i.e., needles, glass) _____

Medications _____

Expired Medications _____

Liquid Biohazards (i.e., blood) _____

Radioactive Material _____

Other _____

15. **Does the facility have a medical waste disposal contractor?**
○ No
○ Yes. Contractor name and phone number:

_____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

16. **Is there laundry service at the facility?**
    ○ Yes   ○ No

* 17. **Is there a kitchen at the facility?**

    (If NO, you do not need to answer any more questions on this page. Click 'Next')
    ○ Yes   ○ No

18. **Indicate the hours the facility is open and the typical number of meals served:**

	Hours of Operation	Typical Number of Meals Served
Monday	—	—
Tuesday	—	—
Wednesday	—	—
Thursday	—	—
Friday	—	—
Saturday	—	—
Sunday	—	—

19. **Indicate which fixtures are in the kitchen and if they are plumbed to a grease trap or interceptor:**

	Number in Kitchen	Plumbed to grease trap or interceptor? (Y/N)
Dishwasher	—	—
Pot sinks	—	—
Multi-compartment sink	—	—
Mop sink	—	—
Floor drain	—	—
Food steamer	—	—
Food grinder/pulper	—	—
Steam kettle	—	—
Can washer	—	—

20. **Have you observed any problems in the kitchen, such as a slow-running drain or an overflow?**
    ○ No
    ○ Yes. Please Describe:

    _____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

* 21. **Does the facility have pretreatment equipment?**
- ❑ No
- ❑ Unsure
- ❑ Yes - grease trap
- ❑ Yes - grease interceptor
- ❑ Yes - other (please describe below):

_____

22. **Provide the following details on pretreatment equipment (if applicable):**

Number of units: _____

Size(s) (in gallons):   _____

Location(s):   _____

How often is the unit(s) serviced (i.e., pumped out/cleaned)?   _____

What company services the unit(s)?   _____

Does management observe servicing of the unit(s)?   _____

Does servicing entail complete cleaning of the unit(s), not just removing the grease layer?   _____

Is the unit(s) refilled with clean water?   _____

Is there a maintenance log available for the unit(s)?   _____

Please complete the following information regarding your business. Red asterisks indicate questions that must be answered.

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* 23. **Does the facility collect medical waste, used fat, oil, or grease in storage bins?**

   (If NO, you do not need to answer any more questions on this page. Click 'Next')

   ○ Yes   ○ No

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24. **Are storage bins placed outside?**

   ○ Yes   ○ No

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25. **Are storage bins kept covered?**

   ○ Yes   ○ No

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26. **Are storage bins located away from storm drains?**

   ○ Yes   ○ No

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27. **Are storage bins checked for leaks?**

   ○ Yes   ○ No

* 28.   **Please read the following statement carefully.**

By entering your name and date below, you certify that you have read the statement and agree with its content.

I certify under penalty of law that I have personally examined and am familiar with the information submitted in this document. Based upon my inquiry of those individuals immediately responsible for obtaining the information reported herein, I believe that the submitted information is true, accurate and complete. I am aware that there are penalties for submitting false information.

Name: _____

Date: _____