CHESPROCOTT HEALTH DISTRICT

1187 HIGHLAND AVENUE, SUITE 210
CHESHIRE • CONNECTICUT
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Kathryn Glendon, MPH, CHES, CPS, Director of Health

APPLICATION FOR DEMOLITION PERMIT

Date:_____

Residential:_____ **Commercial/Industrial:**_____

Building/Structure Address (Street & Town):_____

Property Owner:_____

Property Owner mailing address:_____

Property Owner phone: _____ **Property Owner email:** _____

Please provide description of demolition project:

_____

_____

_____

Provide details of what will occur with existing well and septic system:

_____

_____

Demolition Contractor:

Company Name:_____

Address:_____

(Street, City, State, Zip Code)

Telephone:_____

(Include area code)

Remarks:_____

Staff Review Only

_____APPROVED OR _____DENIED by (Sanitarian)_____Date_____

Fee Paid_____

11/4/25