



Public Bathing Program

____ **Annual Update of Operation**

Section I. Facility Information			
1. Name of Public Bathing Facility:			
Address (include mailing address if different):			
City:	State:	Zip Code:	
Municipality:		County:	
Emergency Phone Number:		Fax:	
Website Address:		Email:	
2. Number of Active Units:	Temporary Closure:	Permanent Closure:**	
3. Facility is Registered as a Non-Profit? <input type="checkbox"/> yes <input type="checkbox"/> no			
4. Change in Ownership? <input type="checkbox"/> yes <input type="checkbox"/> no		Business Owner Name:	
Address:		City:	State: Zip Code:
5. Operator Name:		Onsite <input type="checkbox"/> Contracted <input type="checkbox"/>	
Phone Number:		Fax:	
Email:			
6. Category 24 Certified Pesticide Applicator? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> n/a			
Name:		Certification No:	Expiration Date:

** If all units are permanently closed (removal of unit, filled in units, etc.) complete numbers 1 and 2 of Section I, and return this form and your Bathing Place Permit to appropriate District Office.

Section II. Unit Information (please list any additional units on separate page)	
Unit Type/Name:	Permit No.
a. Volume (gallons):	b. Total Surface Area (Square feet):
c. Turnover Period (hours):	d. Flow Rate (GPM):
e. Number of Bottom Drains:	f. VGBA compliant drain cover (yes/no)?:
Unit Type/Name:	Permit No.
a. Volume (gallons):	b. Total Surface Area (Square feet):
c. Turnover Period (hours):	d. Flow Rate (GPM):
e. Number of Bottom Drains:	f. VGBA compliant drain cover (yes/no)?:
Unit Type/Name:	Permit No.
a. Volume (gallons):	b. Total Surface Area (Square feet):
c. Turnover Period (hours):	d. Flow Rate (GPM):
e. Number of Bottom Drains:	f. VGBA compliant drain cover (yes/no)?:
Unit Type/Name:	Permit No.
a. Volume (gallons):	b. Total Surface Area (Square feet):
c. Turnover Period (hours):	d. Flow Rate (GPM):
e. Number of Bottom Drains:	f. VGBA compliant drain cover (yes/no)?:

Section III. Water Quality and Bacteria Monitoring	
7. At least one weekly bacterial test performed for each unit?	<input type="checkbox"/> yes <input type="checkbox"/> no
8. Contracted Laboratory Name:	
9. Type of Disinfectant Feeder:	
10. Test kit includes DPD method to measure the free Chlorine, and pH testing?	<input type="checkbox"/> yes <input type="checkbox"/> no
11. Daily Performance Log for free chlorine and pH record? <input type="checkbox"/> yes <input type="checkbox"/> no	

Section IV. Electrical Safety	
12. Electrical Inspection Completed for each unit? <input type="checkbox"/> yes <input type="checkbox"/> no	
13. Unit Name and Expiration date per unit:	
<input type="text"/>	<input type="text"/>
14. Electrical Inspection Agency Name:	

Section V. Life Safety	
15. At least one floating and one reaching device for each facility? <input type="checkbox"/> yes <input type="checkbox"/> no	
16. First Aid Kit? <input type="checkbox"/> yes <input type="checkbox"/> no	
17. Number of Lifeguards? _____ (Recreational Swimming Establishments only)	
Only the following certifying agencies are acceptable; check all that apply:	
Red Cross <input type="checkbox"/>	YMCA <input type="checkbox"/> Boy Scouts <input type="checkbox"/> Aquatic Safety <input type="checkbox"/> Star Fish <input type="checkbox"/> Ellis & Assoc. <input type="checkbox"/>

Section VI. Facility Modifications	
18. Were there any modifications in the past year? <input type="checkbox"/> yes <input type="checkbox"/> no (if yes, list changes below)	
Unit Type/Name:	Make/Model No.
a. Disinfectant	
b. Filtration	
c. Circulation	
d. Structural	
e. Water Feature	
f. other	
g. other	

I hereby certify and acknowledge that the statements provided in this form are true and correct to the best of my knowledge, information, and beliefs.

Business Owner or Authorized Representative: _____ **Date:** / /