



Board of Health

Town of Granby

215B West State Street, Granby, MA 01033

Phone (413) 467-7174

Fax (413) 467-3101

POTABLE WATER SUPPLY CERTIFICATE

OWNER'S NAME: _____

ADDRESS: _____

WELL CONSTRUCTION PERMIT: (attach) _____

WELL COMPLETION REPORT: (attach) _____

WATER ANALYSIS: (attach) _____

Bacteriological Analysis: Approved _____ Disapproved _____ Conditional _____

Chemical Analysis: Approved _____ Disapproved _____ Conditional _____

Pesticide Analysis: Approved _____ Disapproved _____ Conditional _____

Additional Analysis: Approved _____ Disapproved _____ Conditional _____

The Board of Health recommends that you test your water every 2-3 years. _____

This is to certify that the well constructed at _____

By _____ is in accordance with the provisions of the Granby Board of Health's Well Regulations and the Commonwealth of Massachusetts.

THIS CERTIFICATION SHALL NOT BE CONSTRUED AS A GUARANTEE THAT THE SYSTEM WILL FUNCTION SATISFACTORY, NOR THAT THE WELL WATER IS FREE OF CHEMICALS NOT INCLUDED IN THE ANALYSIS. THIS CERTIFICATION SHALL NOT BE CONSTRUED AS A GUARANTEE THAT REPEAT WELL WATER ANALYSIS WILL BE WITHIN THE MINIMUM ACCEPTABLE STANDARDS ESTABLISHED BY THE COMMONWEALTH OF MASSACHUSETTS, NOR THAT REPEAT WATER QUALITY TESTING WILL BE WITHIN THE GRANBY BOARD OF HEALTH'S ACCEPTABLE MINIMUM WELL YIELD.

BOARD OF HEALTH'S COMMENTS: _____

AUTHORIZED SIGNATURE: _____

DATE: _____