



Clay County Utility Authority
 3176 Old Jennings Road
 Middleburg, Florida 32068-3907
 Telephone (904) 213-2466
 Fax (904) 213-2467

*Working together to
 protect public health,
 conserve our natural
 resource, and create
 long-term value for our
 ratepayers.*

Request for New Service Turn-On – Commercial

Please complete the form below to have your commercial service turned on at an established commercial location that already has a water meter. This form must be submitted at least 24 hours prior to when you would like service connected to your commercial account. New services are turned on Monday thru Friday.

Account Name:

Name of Business (MUST match EIN/Federal ID number)	d/b/a, if applicable

Contact Information:

Last	First	Middle Initial
Mailing address		Unit # (if applicable)
City	Zip	E-mail Address
Phone numbers		Fax Number
1.	2.	

Identification:

EIN/Federal ID Number	Last 4 digits of Social Security Number (optional)	Date of Birth (optional)
*		

New Service Address to Connect:

Street Address	Unit # (if applicable)
*	
City	Preferred Connection Date:

Do you currently have service with the Authority?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

Do you need to disconnect that service?

<input type="checkbox"/>	YES
<input type="checkbox"/>	NO

If yes, please specify the preferred disconnect date and provide your customer information.

Street Address		Unit # (if applicable)
*		
City	Zip	Preferred Disconnection Date:

Comments:

Please verify that you have entered your information correctly before submitting this form. When submitting this request for new service you are acknowledging that it is your responsibility to be certain that the internal plumbing has been secured and all faucets are in the **OFF** position prior to your initiation of service.



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Commercial Customer Survey

Business Name: _____

Service Address: _____

Type of Business: _____ CCUA Route #: _____

Contact Person: _____ E-mail: _____

Phone #: _____ Fax #: _____

Primary Business: CHECK ALL THAT APPLY

- | | |
|---|--|
| <input type="checkbox"/> Health Care Provider | <input type="checkbox"/> Laundry |
| <input type="checkbox"/> Hospital, Clinic, Laboratory | <input type="checkbox"/> Restaurant |
| <input type="checkbox"/> Veterinary Medicine | <input type="checkbox"/> Hair Salon/Barber Shop |
| <input type="checkbox"/> Photo Finishing | <input type="checkbox"/> Car Dealership/Service Department |
| <input type="checkbox"/> Plating | <input type="checkbox"/> Car Wash |
| <input type="checkbox"/> Pesticides/Fertilizers | <input type="checkbox"/> Docks/ Dockside Facilities |
| <input type="checkbox"/> Nail Salon | <input type="checkbox"/> Day Care |
| <input type="checkbox"/> Assisted Living/Nursing Home | <input type="checkbox"/> Other: _____ |

NAICS Code: _____

ANSWER YES OR NO TO THE FOLLOWING

- _____ Is there a private well on the property?
 _____ Are toxic chemicals used in the production of your goods/ the service you provide?
 _____ Is there a sprinkler system with chemical injectors?

IF ONE OR MORE OF THE ABOVE APPLY, YOU MUST SCHEDULE AN INSPECTION BEFORE SERVICE IS AVAILABLE.

I understand that the CCUA cross-connection control policy requires the potable water service at all commercial accounts be equipped with a reduced pressure backflow assembly. Furthermore, I agree to install and certify a RP immediately downstream of the water meter serving the above location within 30 days, if one is not already installed and certified. I also understand that if a RP is not installed and operating properly, potable water service at this address is subject to termination without any further notification after the 30 days.

Conditions & Comments: _____

Signature _____ Date _____



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NEW USER SURVEY (Non-Residential)

- **General Information:**

- Company Name: _____
Facility Address: _____
Phone #: _____
Mailing Address: _____

- On-site person authorized to represent business: (name & title)

- Property/Facility Owned _____ or Leased _____ If Leased:
Owner's Name: _____
Address: _____
Phone #: _____
- Year Established at this location & brief description of activities conducted:

- **Water Usage & Wastewater Description**

- Will this business discharge any wastewater other than from restrooms to CCUA? _____ If yes, please indicate the source of the wastewater:

- Please indicate all chemicals and products which may be disposed of in the sewage system (attach additional sheets if needed & MSDS sheets if applicable)

Chemical/ Product	Average Quantity (gal/mo)
_____	_____
_____	_____
_____	_____
- How much water do you expect to use? _____ (gal/day)
- Has this facility's wastewater ever been analyzed? _____ If yes, please attach a copy.

- **Certification:** I hereby state that the information contained in this survey is familiar to me, and to the best of my knowledge and belief, such information is true, complete, and accurate.

Signature _____

Printed Name, Title & Date _____



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Floor Wax Stripper Questionnaire

Company Name: _____
Service Address: _____
Contact Name: _____
Phone Number: _____
Janitorial Service Name: _____
Contact Name: _____
Company Address: _____
Phone Number: _____

1. Does your company or your janitorial service company use floor finish or finish stripper products that contain any of the following chemicals?
 1. Monoethanolamine Y/N: _____
 2. Sodium Metasilicate Y/N: _____
2. If you answered Yes to any of the items under 1 above, please indicate how you plan to eliminate your discharge of floor finish stripper waste from the sanitary sewer:
 1. Find alternative products (both floor wax & stripper) that do not contain the above listed chemicals.
Y/N _____ If yes, please provide CCUA with a material Safety Data Sheet (MSDS) for the proposed chemical.
 2. Capture and contain all floor stripper wastewater prior to discharge to the sanitary sewer and transport to an industrial wastewater pretreatment company or another non-CCUA treatment facility for disposal.
Y/N _____ If yes, please indicate what company you plan to use. You will be required to obtain a pretreatment permit from CCUA and to submit copied of hauling records to CCUA for review.
Company or Facility Name: _____
Company Contact: _____
 3. Install and maintain on-site facilities to pre-treat the wastewater prior to discharge to the sanitary sewer.
Y/N: _____ This option will require your company to obtain a permit from the CCUA for the facility to perform monitoring of the industrial wastewater.

Commercial Accounts - Fixture Unit Count

Customer Name : _____
Business Name (DBA) : _____
Occupying Suite No. : _____
Service Address : _____

Date : _____
Type of Business : _____
Square Footage : _____
 Attach Floor Plan if Available

Bathroom Fixtures	Quantity
Lavatory	
Commode - Tank	
Commode - Valve	
Urinal	
Shower	
Floor Drain	

Drain Size _____ No. of SSB _____ Frequency _____

Other Fixtures	Quantity
Utility Sink	
Mop Sink	
Wash Sink	
Bar Sink	
Hand Sink	
Kitchen Sink	
3 Compartment Sink	
2 Compartment Sink	
Interior Hose Bib - Wash Down	
Drinking Fountain	
Floor Drain	
Hub Drain at Grade	
Trench Drain	

No. of Faucets _____
 No. of Faucets _____
 No. of Faucets _____

Drain Size _____ No. of SSB _____ Frequency _____
 Drain Size _____ No. of SSB _____ Frequency _____
 Drain Size _____ No. of SSB _____ Frequency _____

Pet Grooming	Quantity
Wash Tub	
Hair Trap	
Washing Machine Y/N	

Frequency _____ In Drain _____ In Floor _____
 Make _____ Model No. _____

Restaurants	
No. of Seats	Attached
Grease Trap Y/N	
Dishwasher Y/N	

Size (Gallons or lbs) _____ Frequency _____
 Make _____ Model No. _____

Cleaners/ Laundry	
Top Load Commercial Washer	
Front Load Commercial Washer	
Lint Trap Y/N	

Make _____ Model No. _____
 Make _____ Model No. _____
 Trap Size _____ Frequency _____

Automotive Repair & Maintenance	
No. of Bays	
Interior Hose Bib - Wash Down	
Sand Trap	
Oil Trap	

Size (Gallons or lbs) _____ Frequency _____
 Size (Gallons or lbs) _____ Frequency _____

Barber/ Beauty Salon & Spa	
No. of Styling/Barber Chairs	
No. of Shampoo Bowls	
No. of Pedicure Stations	
Washing Machine Y/N	

No. of Hair Traps _____ Frequency _____
 Make _____ Model No. _____

Doctor/ Dentist Office	
No. of Doctors	
No. of Dentist	
No. of Exam Chairs	

Doctor Name(s) _____
 Dentist Name(s) _____

Day Care, School/ Church	
No. of Students	
No. of Sanctuary Seats	
Grease Trap Y/N	

Size (Gallons or lbs) _____ Frequency _____

Comments: _____

Contact Person : _____ **Inspector :** _____
Phone No : Fax _____ **Route No. :** _____
No. : _____ **Meter Size :** _____

Clay County Utility Authority

Seat Count Inventory for Food & Drink Establishments

NAME: _____

Date _____

ADDRESS: _____

Hours of Operation _____ Days _____ Hours _____

INDOOR SEATING COUNT

Tables -

Number of Tables	x	Number of Seats	=	Total Seats
	x	2 seats	=	
	x	4 seats	=	
	x	6 seats	=	
	x	8 seats	=	
	x	10 seats	=	
	x		=	
	x		=	
Total				

Comments: _____

Booths

Number of Booths	x	Number of Seats	=	Total Seats
	x	4 seats	=	
	x	6 seats	=	
	x	8 seats	=	
	x		=	
Total				

Comments: _____

OUTDOOR SEATING COUNT

Number of Tables	x	Number of Seats	=	Total Seats
	x	2 seats	=	
	x	4 seats	=	
	x	6 seats	=	
	x	8 seats	=	
	x	10 seats	=	
	x		=	
	x		=	
Total				

Comments: _____

PLEASE ATTACH A COPY OF THE MENU

BAR SEATING COUNT

Number of Bar Seats _____

BAR SEATING COMMENTS

Comments: _____

I hereby state that the information contained in this seat count inventory is familiar to me and such information is true, complete and accurate. If additional seats are added in the future I am aware that this should be reported to the Utility (15) days prior to the increase in seating and an additional supplemental agreement will be prepared to assess any additional charges to either the tenant or the Property/project owner based on their mutual agreement on the same.

Signature _____

Print Name, Title & Date _____