



Washington County Health Department

1302 Pennsylvania Avenue, Hagerstown, MD 21742

washcohealth.org
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APPLICATION FOR ANNUAL SWIMMING POOL- SPA/HOT TUB - BATHING BEACH OPERATING PERMIT

<input type="checkbox"/> Apartment	<input type="checkbox"/> Community	<input type="checkbox"/> School	
<input type="checkbox"/> Camp	<input type="checkbox"/> Condominium	<input type="checkbox"/> Spa	
<input type="checkbox"/> Club	<input type="checkbox"/> Motel/Hotel	<input type="checkbox"/> Other (Specify) _____	
Application to Operate: (Check all that apply)	<input type="checkbox"/> Indoor	<input type="checkbox"/> Outdoor	<input type="checkbox"/> Swimming Pool
	<input type="checkbox"/> Spa/Hot Tub	<input type="checkbox"/> Bathing Beach	<input type="checkbox"/> Wading Pool

FACILITY

NAME (As it will appear on permit)	TELEPHONE
STREET ADDRESS	TELEPHONE - CELL
CITY/STATE/ZIP	EMAIL ADDRESS

Permit Mailing Address _____
STREET ADDRESS
CITY/STATE/ZIP

OWNERSHIP

INDIVIDUAL _____
Individual Owner Name

CORPORATION	Corporation Name	Name of Corporation President
	Street Address	Telephone
	City/State/Zip	Email Address

Pool Management Company/Certified Operator _____

Days and Hours of Operation _____

Telephone Number of Pool/Spa/Beach _____

Date Signature of Owner/Agent

Returned check fee \$25

Office use only

Rev Oct 2022

RECEIPT NO _____ PERMIT NO _____ DATE ISSUED _____

ENVIRONMENTAL HEALTH

240-313-3400 Voice • Call 711 for MD Relay TTY • 240-313-3424 Fax
wchd.eh@maryland.gov



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STATEMENT OF WORKERS' COMPENSATION INSURANCE

Maryland Health-General Code Annotated Section I-202 requires that before any license or permit be issued under the Health-General Article to an employer to engage in an activity in which the employer may employ any individual, the employer must file with the issuing authority a certificate of compliance with the State workers' compensation laws indicating the employer's workers' compensation insurance policy or binder number.

Circle the number of the option below which applies to you, provide the requested information, sign and date the form, and return it with the attached application.

1. I have workers' compensation insurance.

Insurance Company _____

Policy or Binder number _____

2. A waiver has been received from the Workers' Compensation Commission. (ATTACH A COPY OF THE WAIVER.)
3. As provided by Maryland Annotated Code Article 101, I am exempt from having workers' compensation insurance. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE.)
4. I am self-insured. Approval of self-insurance has been received from the Workers' Compensation Commission. (ATTACH A COPY OF THE CERTIFICATE OF COMPLIANCE.)

Date

Signature

Company Name

Title

Address

Type of License

City

St

Zip

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