

**KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT  
WASTEWATER BYPASS REPORT FORM**

1. FACILITY NAME: \_\_\_\_\_ Kansas Permit # \_\_\_\_\_

2. Within 24 Hours of Discovery, Notify the KDHE Central Office (email – [cseeds@kdheks.gov](mailto:cseeds@kdheks.gov)), (fax 785.296.0086), (telephone 785.296.5517) or your KDHE local district office. Written notification required within 5 days of discovery.

KDHE Person Contacted: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

3. Date Bypass Discovered: \_\_\_\_\_ Time: \_\_\_\_\_

4. Date Bypass Ended: \_\_\_\_\_ Time: \_\_\_\_\_

Total Estimated Gallons Bypassed for All Locations on this Form: \_\_\_\_\_

6. If rainfall event, approximate inches of rainfall \_\_\_\_\_

If multiple bypass locations listed below due to rain event, check here \_\_\_\_\_

7. Bypass Location: (check all that apply)

- |                         |                             |
|-------------------------|-----------------------------|
| _____ Plant             | _____ City Collection Line  |
| _____ Lift/Pump Station | _____ Private Sewer Line    |
| _____ Peak Flow Basin   | _____ Other (specify below) |
| _____ Manhole(s)        |                             |

Identify Bypass Location by Name, Street Address or Manhole Number as appropriate

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8. Cause of Bypass: (definitions available at <http://www.kdheks.gov/water/tech.html> )

- |  |                                   |
|--|-----------------------------------|
| _____ Intentional Bypass for Repair/Construction | _____ Equipment Failure           |
| _____ Excessive Rainfall, Snow Melt              | _____ Control System Failure      |
| _____ Unplanned Construction Related Break       | _____ Power Related Failure       |
| _____ City Line Break (Not Construction Related) | _____ Operations Related Failure  |
| _____ City Line Blockage                         | _____ Maintenance Related Failure |
| _____ Private Line Break                         | _____ Vandalism                   |
| _____ Private Line Blockage                      | _____ Spill                       |
| _____ Lagoon High Level                          | _____ Other                       |

Additional explanation of reason for bypass: (use additional page if necessary)

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9. Corrective Action, if any: (use additional page if necessary)

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

When Completed, Mail to: Kansas Department of Health and Environment  
Attn: Chris Seeds  
1000 SW Jackson St., Suite 420  
Topeka, KS 66612-1367