

OFFICE USE O	NLY:		
Date: Parcel #: Waterfront	Yes	No	PERMIT #: Zoning District:

## **Zoning Department**

1156 Alpine Drive Phone: 715 325-8019 Nekoosa, WI 54457 Fax: 715 325-8035

Email: zoning@romewi.com

www.romewi.com

## **CERTIFIED SURVEY MAP**

\$100.00 PROCESSING FEE

## PLEASE PRINT CLEARLY & FILL OUT COMPLETELY

Mailing Address:  Surveyor:  Date Received:  Date Surveyed:  IMPORTANT NOTES: UNDERSIGNED FURTHER AKNOWLEDGES: (1) THAT THE SIGNATURE BELOW ALSO GRANTS CONSENT FOR DEPARTMENT STO ENTER PROPERTY. (2) YOU UNDERSTAND THAT YOU WILL BE BILLED ON A MONTHLY BASIS FOR THE CSM PROCESSING FEE(S). (3) 1% PENALTY PER MON NOT PAID BY DUE DATE.  Signature:  Contact #:  Printed Name:  E-mail:  Company Name:  Billing Address:	Date:		
Parcel Number/Tax Key:    Date By (If Applicable):	Property Description:		
Owned By (If Applicable):	Primary Property Address:		
Mailing Address:	Parcel Number/Tax Key:		
Mailing Address:	Owned By (If Applicable):		Phone:
Date Received:  Date Surveyed:  IMPORTANT NOTES: UNDERSIGNED FURTHER AKNOWLEDGES: (1) THAT THE SIGNATURE BELOW ALSO GRANTS CONSENT FOR DEPARTMENT ST TO ENTER PROPERTY. (2) YOU UNDERSTAND THAT YOU WILL BE BILLED ON A MONTHLY BASIS FOR THE CSM PROCESSING FEE(S). (3) 1% PENALTY PER MON NOT PAID BY DUE DATE.  Signature:  Contact #:  Printed Name:  E-mail:  Company Name:  Billing Address:  OFFICE USE ONLY:  CSM: \$ 100.00	Mailing Address:	{Last}	
Date Surveyed:  IMPORTANT NOTES: UNDERSIGNED FURTHER AKNOWLEDGES: (1) THAT THE SIGNATURE BELOW ALSO GRANTS CONSENT FOR DEPARTMENT ST TO ENTER PROPERTY. (2) YOU UNDERSTAND THAT YOU WILL BE BILLED ON A MONTHLY BASIS FOR THE CSM PROCESSING FEE(S). (3) 1% PENALTY PER MON NOT PAID BY DUE DATE.  Signature:  Contact #:  Printed Name:  E-mail:  Company Name:  Billing Address:  OFFICE USE ONLY:  CSM: \$\frac{100.00}{200.00} Approved by:  (check # or credit card) Date:  Date:  Date:			
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Printed Name: E-mail:  Company Name:  Billing Address:  OFFICE USE ONLY: Approved by: Date:  Paid: \$ (check # or credit card) Denied by: Date:		U WILL BE BILLED ON A MONTHLY BASIS FOR THE CSM PROCESS	
Company Name:	Signature:	Contact #:	
Billing Address:	Printed Name:	E-mail:	
OFFICE USE ONLY:  CSM: \$ 100.00	Company Name:		
CSM: \$ 100.00   Approved by: Date: Paid: \$	Billing Address:		
Paid: \$	OFFICE USE ONLY:		
(check # or credit card)  Denied by: Date:		Approved by:	Date:
By: Comments / Conditions:	(check # or credit card)	Denied by:	Date:
	By:	Comments / Conditions:	