

Form 7-6 Operational Checklist: DISINFECTION UNIT – ULTRAVIOLET LIGHT (DUUL)

Service provided on: Date: _____ Time: _____ Reference #: _____
 Service provided by: Company: _____ Employee: _____
 Date of last service: _____ By: ☐ You ☐ Other: _____
 Date of last inspection: _____

NOTES

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| <p>1. Power supply</p> <p>a. Dosing method: <input type="checkbox"/> Pressure dosed <input type="checkbox"/> Gravity fed</p> <p>b. Manufacturer: _____ Model #: _____</p> <p>c. Power supplied to the unit. Yes _____ No _____</p> <p>d. UV lamp 'ON'. Yes _____ No _____</p> <p>e. Electrical system is free of corrosion/damage. Yes _____ No _____</p> <p>f. Ballast replaced during this visit. Yes _____ No _____</p> <p>g. Last replacement date: _____ / _____ / _____</p> <p>2. UV controls</p> <p>a. Unit equipped with a lamp intensity sensor. Yes _____ No _____</p> <p>b. If so, what was intensity reading: _____</p> <p>c. Alarm present. Yes _____ No _____</p> <p>d. Alarm operating properly. Yes _____ No _____</p> <p>3. Contact chamber, lamp, and sleeve conditions</p> <p>a. Evidence of damage or leakage. Yes _____ No _____</p> <p>b. Contact chamber cleaned/flushed of solids. Yes _____ No _____</p> <p>c. Type of protective sleeve: <input type="checkbox"/> Quartz <input type="checkbox"/> Teflon <input type="checkbox"/> Other: _____</p> <p>d. Protective sleeve free of buildup. Yes _____ No _____</p> <p>e. Protective sleeve cleaned. Yes _____ No _____</p> <p>f. Protective sleeve replaced during this visit. Yes _____ No _____</p> <p>g. Date last replaced: _____ / _____ / _____</p> <p>h. UV lamp replaced during this visit. Yes _____ No _____</p> <p>i. Date last replaced: _____ / _____ / _____</p> <p>4. Influent characteristics</p> <p>a. Turbidity: _____ NTU</p> <p>b. Flow rate: _____ gpm</p> <p>c. Indicate wastewater characteristics that may compromise treatment: _____</p> <p>5. Control panel: N.A. _____</p> <p>a. Controls operating properly. Yes _____ No _____</p> <p>b. Is enclosure watertight. Yes _____ No _____</p> <p>c. Alarm test switch operating properly. Yes _____ No _____</p> <p>d. At time of inspection, control switch was set to: N.A. _____
 "Hand/Manual" _____
 "Auto" _____</p> <p>e. If auto, setting: Time on: _____ (min) Time off: _____ (min)</p> <p>6. Housing unit: Location: _____</p> <p>a. Appears in good condition. Yes _____ No _____</p> <p>b. Leaks/Cracks present. Yes _____ No _____</p> <p>c. Excessive dust present. Yes _____ No _____</p> <p>7. Manufacturer's required maintenance performed. Yes _____ No _____
 (If 'Yes', attach Manufacturers Inspection form to this report, if supplied)</p> <p>8. Lab samples collected for monitoring. Yes _____ No _____
 Types of analysis: _____</p> | <p>1. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> <p>2. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> <p>3. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> <p>4. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> <p>5. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> <p>6. <input type="checkbox"/> Acceptable
 <input type="checkbox"/> Unacceptable</p> |
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