

Form 8-2 Operational Checklist: Evapotranspiration beds (ETB)

Service provided on: Date: _____ Time: _____ Reference #: _____

Service provided by: Company: _____ Employee: _____

Date of last service: _____ By: You Other: _____

Date of last inspection: _____

NOTES

1. Conditions at the ET bed

a. Evaluate presence of odor within 10 ft of perimeter of system:

None Mild Strong Chemical Sour

b. Source of odor, if present: _____

c. Indications of leaks around/above system. Yes _____ No _____

d. Vegetation appropriate. Yes _____ No _____

e. Excessive vegetative growth. Yes _____ No _____

f. Vegetation adequately maintained. Yes _____ No _____

g. Preventing accessibility for maintenance. Yes _____ No _____

1. Acceptable
 Unacceptable

2. Distribution to ET bed

a. Method for dosing:

Gravity-to-gravity Pump-to-gravity

b. Type: Distribution box Drop box Header

Pressure manifold Other: _____

c. If pressure manifold, distal head: _____

d. Accessible. Yes _____ No _____

e. Intact, providing equal distribution. Yes _____ No _____

f. Free of solids. Yes _____ No _____

g. If 'No' depth of solids below outlet. _____ in

h. Root intrusion. Yes _____ No _____

2. Acceptable
 Unacceptable

3. Switching valve

a. Switching valve present. Yes _____ No _____

b. Type of valve: _____

c. Operating properly. Yes _____ No _____

d. Action taken if not: _____

e. Bed in operation: _____

3. Acceptable
 Unacceptable

4. ET bed:

Bed #	Status		Ponding		Surfacing Effluent (Yes – No)	ET Bed Surface Shedding Rainwater (Yes-No)
	Current	End of Service	Yes-No	Depth (in)		
1	<input type="checkbox"/> Active <input type="checkbox"/> Resting	<input type="checkbox"/> Active <input type="checkbox"/> Resting				
2	<input type="checkbox"/> Active <input type="checkbox"/> Resting	<input type="checkbox"/> Active <input type="checkbox"/> Resting				

5. Inspection ports

a. Inspection ports present. Yes _____ No _____

b. Inspection ports intact. Yes _____ No _____