



Office Use Only	
Scanned	
Recorded in Database	
Report to Agency	

## OMNI-CYCLE MAINTENANCE CHECKLIST

### SITE VISIT INFORMATION

Project Name:		Date:	
Actual Flow:		Operator:	
Alarm Condition:	Yes <input type="checkbox"/> No <input type="checkbox"/>	System Condition:	
Operating Correctly:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Results Pending:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Call Back Note Left:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seasonal Residence:	Yes <input type="checkbox"/> No <input type="checkbox"/>

### SEPTIC TANK / ANOXIC TANK

Septic Tank Inspected:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Effluent Filters Present:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Scum Depth (Inches):		Effluent Filters Cleaned:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sludge Depth (Inches):		Pumping Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>

### RECIRCULATION TANK AND EQUALIZATION TANK

Recirculation Tank Inspected:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Effluent Filters Present:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Unusual Odor or Condition:		Effluent Filters Cleaned:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Float Switches Inspected:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Alarm Tested: (Audible/Visual)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sludge Depth (Inches):		Pumping Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anoxic Zone Sludge (Inches):		Pumping Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Anoxic Zone Liquid Level		Media Replacement Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>

### FILTER MODULES / BED

Filter Modules Inspected:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Distribution System Brushed:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Distribution Pipes Inspected:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Distribution System Flushed:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Bed Maintenance Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Action Taken:	
Head Loss Measurement:			

### PUMP CHAMBER / FINAL DOSING TANK

Pump Tank Inspected	Yes <input type="checkbox"/> No <input type="checkbox"/>	Sludge Present:	Yes <input type="checkbox"/> No <input type="checkbox"/>
		Pumping Required:	Yes <input type="checkbox"/> No <input type="checkbox"/>

### CONTROLS INFORMATION

Access To Controls:				Yes <input type="checkbox"/> No <input type="checkbox"/>		Controls Inspected:				Yes <input type="checkbox"/> No <input type="checkbox"/>	
ON (min)	OFF (min)	OVRON (min)	OVROFF (min)	P#1 Count	P#1 ETM	P#2 Count	P#2 ETM	OVR 1 Count	OVR 2 Count		

High Level Count	Low Level Count	Power Faults	Operating Hours	Timer Flt Count

### SAMPLING DATA

DO ST	DO RT	ORP RT	Ammonia	Nitrate	Ph	Alkalinity	Temp	Back Flow Rate	Forward Flow Rate

### GENERAL INFORMATION

Additional Follow-up Needed:	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Inspection Notes:		