BIO-MICROBICS® INCORPORATED
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FIELD INSPECTION & SERVICE REPORT
RetroFAST® Wastewater Treatment Systems

INSTALLATION	AUTHORIZED SERVICE PROVIDER
Installation Address:	Name:
Owner Name:	Street:
Mail Address: City State Zip	Mail Address: City State Zip
Phone Fax e-mail	Phone Fax e-mail

INSTALLATION INFORMATION

Model No.	Blower Brand and Size	Serial No.	Date of Installation	Date of last pump-out

EQUIPMENT OPERATION	YES	NO	DETAILED COMMENTS OF SITE CONDITIONS – MAINTENANCE PERFORMED OR REQUIRED
Electrical Panel(s)			
Visual Alarm Operating			
Audio Alarm Operating (if present)			
Blower(s):			
Air Inlet Filter Clean			
Blower Hood Vents Clear			
Excessive Noise			
Excessive Vibration			
Treatment Unit(s):			
Unusual Odor			
System Vent			
Pumpout Required:			
Primary Settling Zone			
Aerobic Treatment Zone			
EFFLUENT:	**LIMIT**	**RESULT**	
Estimated Daily Flow			
pH (Standard Units)	6-9 S.U.		
Color	Clear		
Temperature			
Dissolved Oxygen (effluent)	2 mg/L		
Odor	Musty odor (not septic)		
Water depth in D-box	inches		

Water Depth in SAS port(s) in inches _____

Signs of sewage ponding in SAS area?

OWNER SIGNATURE	TECHNICIAN SIGNATURE	SERVICE DATE