



COUNTY OF KENOSHA

Department of Planning and Development

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SERVICE AND REPLACEMENT DEVICE REPORT FORM

Sanitary Permit #:

Tax Parcel #:

Existing treatment device type (e.g. UV light):

New Supplemental Treatment Device Manufacturer

Name: _____

Contact Phone Number: _____

Website address: _____

Device Model or Catalog Number: _____

Device Brand Name: _____

Manufacturer's Specified Rated Effective Life (hrs.): _____

Replacement Product Installation Date: _____

Service Provider's Name: _____

Service Provider's Company Name: _____

Service Provider's Phone Number: _____

Notes & Comments:

Please attach manufacturer's support documents and materials for the newly installed replacement device to this report form. These documents are required for submittal with this report form for the County to confirm and record the next product service interval date.