

FLUID LIFE

EQUIPMENT RELIABILITY SERVICES

CUSTOMER: _____

UNIT #: _____

COMPONENT: _____

LOCATION: _____

SAMPLE DATE: _____

PLEASE RETAIN THIS PORTION OF THE SLIP FOR RECORD OF SAMPLE

CUSTOMER CARE GROUP:

TOLL FREE 877.962.2400 www.fluidlife.com

TRACKING #

FLUID LIFE

EQUIPMENT RELIABILITY SERVICES

SAMPLE DATE: _____

COMPANY: _____

CONTACT: _____

ADDRESS: _____

CITY: _____

PROV/STATE: ____ POSTAL/ZIP: _____

PHONE: _____

FAX: _____

EMAIL: _____

PLEASE INCLUDE SAMPLE CARD INFORMATION WITH YOUR SAMPLE

TRACKING #

LAB USE ONLY

UNIT #: _____ HR/MO/KM/MI OIL MANUFACTURER: _____

SITE LOCATION: _____ ON COMPONENT: _____ OIL BRAND: _____

SERIAL #: _____ ON OIL: _____ OIL GRADE: _____

COMPONENT MANUFACTURER: _____ METER READING: _____ OIL CHANGED: ☐ YES ☐ NO

MODEL #: _____ AMOUNT MAKEUP OIL ADDED: _____ COMMENTS OR ADDITIONAL INFORMATION: _____

SYSTEM CAPACITY: _____ L/GAL _____

COMPONENT

- | | |
|---------------------------------------|---|
| <input type="checkbox"/> ENGINE | <input type="checkbox"/> SCREW COMPRESSOR |
| <input type="checkbox"/> TRANSMISSION | <input type="checkbox"/> WHEEL MOTOR |
| <input type="checkbox"/> HYDRAULICS | <input type="checkbox"/> BEARING |
| <input type="checkbox"/> DIFFERENTIAL | <input type="checkbox"/> TURBINE |
| <input type="checkbox"/> COMPRESSOR | <input type="checkbox"/> GEARBOX |
| <input type="checkbox"/> OTHER: _____ | <input type="checkbox"/> TYPE: _____ |

LOCATION

- | | | |
|--------------------------------|--------------------------------------|---|
| <input type="checkbox"/> LEFT | <input type="checkbox"/> REAR | <input type="checkbox"/> BEFORE FILTERS |
| <input type="checkbox"/> FRONT | <input type="checkbox"/> BOTTOM | <input type="checkbox"/> OUTBOARD |
| <input type="checkbox"/> TOP | <input type="checkbox"/> SOUTH | <input type="checkbox"/> RETURN LINE |
| <input type="checkbox"/> NORTH | <input type="checkbox"/> WEST | <input type="checkbox"/> AFTER FILTERS |
| <input type="checkbox"/> EAST | <input type="checkbox"/> AUXILIARY | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> MAIN | <input type="checkbox"/> INBOARD | _____ |
| <input type="checkbox"/> RIGHT | <input type="checkbox"/> SUPPLY LINE | _____ |

FUEL

- | | |
|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> DIESEL | <input type="checkbox"/> PROPANE |
| <input type="checkbox"/> NATURAL GAS | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> GAS | |

POWER TYPE

- | |
|--------------------------------------|
| <input type="checkbox"/> STEAM |
| <input type="checkbox"/> ELECTRICITY |
| <input type="checkbox"/> MECHANICAL |
| <input type="checkbox"/> FLUID |

COOLANT

- | | |
|--|---------------------------------------|
| <input type="checkbox"/> CONVENTIONAL GLYCOL | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> ELC GLYCOL | |
| <input type="checkbox"/> WATER | |
| <input type="checkbox"/> AIR | |

COMPLETE SAMPLE INFORMATION IS REQUIRED FOR ACCURATE INTERPRETATION OF RESULTS