



Fluid Life

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**RETURN WHITE COPY WITH SAMPLE
 TIGHTEN JAR LID SECURELY**

SAMPLE DATE: _____

COMPANY: _____

CONTACT: _____

ADDRESS: _____

CITY: _____

PROVINCE: _____ POSTAL CODE: _____

PHONE:() _____

FAX:() _____

COMPLETE SAMPLE INFORMATION IS REQUIRED FOR ACCURATE INTERPRETATION OF RESULTS

SITE LOCATION: _____ COMPONENT MANUFACTURER: _____

UNIT #: _____ SERIAL #: _____ MODEL #: _____

HR/MO/KM/MI ON COMPONENT: _____ ON OIL: _____ OIL MAKE: _____ OIL BRAND: _____ OIL GRADE: _____

WAS OIL CHANGED? YES NO AMOUNT MAKEUP OIL ADDED: _____ CAPACITY OF OIL SYSTEM: _____ L. GAL.

RECENT REPAIRS: _____

COMPONENT:	FUEL:	POWER TYPE:	COOLANT:	LOCATION: (Multiple choices may be used in this area)
<input type="checkbox"/> ENGINE <input type="checkbox"/> TURBINE	<input type="checkbox"/> DIESEL <input type="checkbox"/> STEAM		<input type="checkbox"/> GLYCOL	<input type="checkbox"/> MAIN <input type="checkbox"/> UPPER <input type="checkbox"/> NORTH <input type="checkbox"/> INNER/INBOARD
<input type="checkbox"/> COMPRESSOR <input type="checkbox"/> BEARING CASE	<input type="checkbox"/> GASOLINE <input type="checkbox"/> ELECTRIC		<input type="checkbox"/> DOWTHERM	<input type="checkbox"/> AUXILIARY <input type="checkbox"/> LOWER <input type="checkbox"/> SOUTH <input type="checkbox"/> OUTER/OUTBOARD
<input type="checkbox"/> HYDRAULICS <input type="checkbox"/> WHEEL MOTOR	<input type="checkbox"/> PROPANE <input type="checkbox"/> MECHANICAL		<input type="checkbox"/> WATER	<input type="checkbox"/> FRONT <input type="checkbox"/> TOP <input type="checkbox"/> EAST <input type="checkbox"/> LEFT/PORT
<input type="checkbox"/> HYDROSTATIC TRANSMISSION	<input type="checkbox"/> CNG <input type="checkbox"/> FLUID		<input type="checkbox"/> AIR	<input type="checkbox"/> REAR <input type="checkbox"/> CENTER <input type="checkbox"/> WEST <input type="checkbox"/> RIGHT/STARBOARD
<input type="checkbox"/> MANUAL TRANSMISSION	<input type="checkbox"/> OTHER _____		<input type="checkbox"/> OTHER _____	<input type="checkbox"/> RESERVOIR <input type="checkbox"/> BOTTOM <input type="checkbox"/> IN LINE <input type="checkbox"/> AFTER FILTERS
<input type="checkbox"/> OTHER _____				<input type="checkbox"/> OTHER _____ <input type="checkbox"/> BEFORE FILTERS
<input type="checkbox"/> GEAR BOX Describe type: _____				

IF EXTRA TESTS REQUIRED ENCLOSE ORDER FORM