

VEHICLE MAINTENANCE OPERATIONS FORM

Legal Business Name: _____
Facility Name: _____

Section A: Operation Description

- 1. Operation description:
 - a) Date facility began operating (mo/yr): _____
 - b) Size of vehicle maintenance operation (square feet): _____
 - c) Number of service bays: _____
 - d) Average number of employees: _____
 - e) Expected daily average number of vehicles: _____
 - f) Days of Operations
(check all that apply)

<input type="checkbox"/> Sunday	<input type="checkbox"/> Monday	<input type="checkbox"/> Tuesday	<input type="checkbox"/> Wednesday	<input type="checkbox"/> Thursday	<input type="checkbox"/> Friday	<input type="checkbox"/> Saturday
---------------------------------	---------------------------------	----------------------------------	------------------------------------	-----------------------------------	---------------------------------	-----------------------------------
 - g) Hours of Operation: _____
 - h) Best time for inside inspections: _____

Section B: Facility Description

- 1. Type of vehicle services at this facility: (check all that apply)

<input type="checkbox"/> Oil Changes	<input type="checkbox"/> Engine Repair	<input type="checkbox"/> Parts Storage	<input type="checkbox"/> Car Washing
<input type="checkbox"/> Brake Repair	<input type="checkbox"/> Auto Detailing	<input type="checkbox"/> Body Work	<input type="checkbox"/> Interior Cleaning
<input type="checkbox"/> Tire Repair	<input type="checkbox"/> Automotive Glass	<input type="checkbox"/> Auto Painting	<input type="checkbox"/> Large Vehicles
<input type="checkbox"/> Transmission Repair	<input type="checkbox"/> Auto Storage/Parking	<input type="checkbox"/> Tank Interior Cleaning	<input type="checkbox"/> Other _____

- 2. Location of vehicle service facility: (check all that apply)

<input type="checkbox"/> Car Dealer	<input type="checkbox"/> Club/Organization	<input type="checkbox"/> Company/Office Building	<input type="checkbox"/> Hospital
<input type="checkbox"/> Hotel / Motel	<input type="checkbox"/> Mall	<input type="checkbox"/> Nursing Home	<input type="checkbox"/> Prison
<input type="checkbox"/> Religious Institution	<input type="checkbox"/> School	<input type="checkbox"/> Stadium/Amusement Park	<input type="checkbox"/> Gas Station
<input type="checkbox"/> Stand-alone Strip Mall (attached)	<input type="checkbox"/> Other _____		

- 3. Major equipment used for at this facility: (check all that apply or submit a copy of your company's equipment schedule)

<input type="checkbox"/> Vehicle Lifts	<input type="checkbox"/> Solvent Cabinet	<input type="checkbox"/> Mobile Drain Rigs	<input type="checkbox"/> Exterior Parking
<input type="checkbox"/> Parts Washers	<input type="checkbox"/> Paint Cabinet	<input type="checkbox"/> Used Oil Rag Bins	<input type="checkbox"/> Interior Parking
<input type="checkbox"/> Air Compressor	<input type="checkbox"/> Paint Booth	<input type="checkbox"/> Refrigerant Equipment	<input type="checkbox"/> Oil Drum Rack
<input type="checkbox"/> Other _____			

- 4. Fixtures in the automotive work areas: (check all that apply)

<input type="checkbox"/> Service Sink	<input type="checkbox"/> Floor Drain	<input type="checkbox"/> Flushing Rim Sink	<input type="checkbox"/> Flush Valve Sink
<input type="checkbox"/> Mop Sink	<input type="checkbox"/> Pre-Rinse Sink	<input type="checkbox"/> Hand Sink	<input type="checkbox"/> Trench Drain
<input type="checkbox"/> Other _____			

Section C: Waste Management

Trash / Solid Waste Disposal

1. Type of collection receptacle(s): (check all that apply)
 Cans Dumpster Compactor Other _____
2. Location of collection receptacle(s): _____
3. Frequency of pick-up: _____
4. Trash removal service (business name and address): _____

5. Do you share the use of the trash receptacle(s)? Yes No
6. How does your facility dispose of old tires? _____
7. How does your facility dispose of used/removed parts? _____

Used Oil and Fluid Management

8. Does your company have a used oil tank or other fluid collection? Yes No
9. Location of used oil/fluid tank(s) : Inside Outside
10. Size (capacity) of used oil/fluid tank(s): _____
11. Do you burn or reuse the collected used fluids? Yes No
12. How often do you empty the tank(s)? (check)
- | | | | | |
|------------------------------------|---------------------------------------|-----------------------------------|------------------------------------|------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Weekly | <input type="checkbox"/> Biweekly | <input type="checkbox"/> Monthly | <input type="checkbox"/> Bimonthly |
| <input type="checkbox"/> Quarterly | <input type="checkbox"/> Semiannually | <input type="checkbox"/> Annually | <input type="checkbox"/> As Needed | <input type="checkbox"/> Never |
13. Disposal service contractor (business name and address): _____

14. Does your facility have an oil/water separator? Yes No
If yes, provide name of disposal service contractor (business name and address): _____

Certification

"I certify under penalty of law that this document and all attachments were prepared under my direction or supervision in accordance with a system designed to assure that qualified personnel properly gather and evaluate the information submitted. Based on my inquiry of person or persons who manage the system, or those persons directly responsible for gathering the information, the information submitted is, to the best of my knowledge and belief, true, accurate, and complete. I am aware that there are significant penalties for submitting false information, including the possibility of fines and imprisonment for knowing violations."

Signature of Duly Authorized Representative

Printed Name

Date