NCDH-AALLDPT-TO

NASSAU COUNTY DEPARTMENT OF HEALTH

200 COUNTY SEAT DRIVE
MINEOLA, NY 11501

PHONE: (516) 227-9691 FAX: (516) 227-9613

FOR OFFICE USE ONLY

ANNUAL AUTOMATIC LINE LEAK DETECTOR PERFORMANCE TEST

PLEASE TYPE OR PRINT CLEARLY - *Information you provide should match that of the permit issued to the facility.*

A. FACILITY INFORMATION

CONTACT NAME	TELEPHONE NUMBER	EMAIL ADDRESS

FACILITY NAME	FACILITY ID #

ADDRESS	CITY	STATE	ZIP

MAILING ADDRESS	CITY	STATE	ZIP

PERMITTEE INFORMATION

PERMITTEE NAME	TELEPHONE NUMBER

ADDRESS	CITY	STATE	ZIP

CONTRACTOR INFORMATION

COMPANY NAME	TELEPHONE/CELL NUMBER

TECHNICIAN NAME	TANK TESTER CERTIFICATE OF FITNESS #	EXPIRATION DATE

CONTACT PERSON	E-MAIL	WORK ORDER NUMBER

All of the applicable fields on this form must be used to document automatic line leak detector performance. A copy of this form, or one similar to it with all of the applicable information provided, must be provided to the tank system owner/operator. The owner/operator must retain these records in accordance with Nassau County Public Health Ordinance, Article XV.

B. SYSTEM INFORMATION & TESTING REQUIREMENTS

REASON FOR TEST: ☐ ANNUAL ☐ NEW INSTALLATION ☐ TROUBLESHOOTING ☐ LEAK INVESTIGATION ☐ OTHER

DATE OF TESTING/SERVICING: START TIME: AM PM END TIME: AM PM

DESCRIPTION	LINE # / PRODUCT	LINE # / PRODUCT	LINE # / PRODUCT	LINE # / PRODUCT	LINE # / PRODUCT	LINE # / PRODUCT
LINE NUMBER / PRODUCT						
ALLD MANUFACTURER						
ALLD MODEL						
ALLD SERIAL NUMBER						
C. MECHANICAL ALLD TEST DATA						
STP FULL OPERATING PRESSURE (PSI)						
HOLDING PRESSURE (PSI)						
RESILIENCY/BLEEDBACK (ML)						
STEP THROUGH TIME (SECONDS)						
METERING PRESSURE (PSI)						
OPENING TIME (SECONDS)						
LEAK TEST PRESSURE (PSI)						
LEAK TEST VOLUME (ML)						
TEST LEAK RATE (GPH)						
Does the STP pressure remain at or below the metering pressure for at least 60 seconds when the simulated leak is induced?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Does the leak detector reset (trip) when the line pressure is bled off to zero PSI?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
Does the STP properly cycle on / off under normal fuel system operation conditions?	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

FACILITY ID # FACILITY NAME: DATE:

D. ELECTRONIC ALLD TEST DATA						
SET-UP PARAMETERS CORRECT	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
FULL PUMP PRESSURE (PSI)						
SIMULATED LEAK CAUSES AUDIBLE OR VISUAL ALARM	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
SIMULATED LEAK CAUSES PUMP SHUTDOWN	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO
NUMBER OF TEST CYCLES BEFORE ALARM OR PUMP SHUTDOWN OCCURS						
E. TEST RESULTS						
PASS / FAIL						

NOTE: ***If response is "FAIL" for any ALLD above***; call NCDH and NYSDEC immediately and send this form to NCDH via fax.

A copy of this form, or one similar to it with all of the applicable information provided, must be sent to the Nassau County Department of Health with the applicable fees. This test **MUST** be performed on an annual basis, and results **MUST** be submitted on a biennial basis in accordance with Nassau County Public Health Ordinance, Article XV.

COMMENTS:

Operator was advised to hire contractor to correct deficiencies or service items not inspected or verified: ☐ YES ☐ NO ☐ NA (No deficiencies or items not inspected or verified)

Certification - I certify that the equipment identified in this document was inspected/serviced in accordance with the manufacturers' guidelines and the system is set up correctly. Attached to this report is additional documentation (e.g. manufacturers' checklists) necessary to verify that this information is correct. For any equipment capable of generating such reports, I have also attached a copy of the following; *(check all that apply):*

☐ Set-up as found ☐ Set-up as left (corrections made: ☐ YES ☐ NO) ☐ Alarm History

TECHNICIAN NAME (PRINT) SIGNATURE DATE OF TESTING/SERVICING

FACILITY REPRESENTATIVE (PRINT) SIGNATURE DATE OF TESTING/SERVICING