Complete this report at the time of the regular monthly preventive maintenance check (not to exceed 35 days). Complete this report whenever the instrument is serviced or repaired and whenever it is placed into service. Retain the original and send a copy within 15 days to the Breath Alcohol Program, DHSS.

<table>
<thead>
<tr>
<th>INTOX DMT SN</th>
<th>NAME OF AGENCY</th>
<th>DATE OF INSPECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>LOCATION OF INSTRUMENT (STREET AND CITY)</td>
<td>TIME OF INSPECTION</td>
<td></td>
</tr>
</tbody>
</table>

**CHECKLIST:** Place a mark on the line by each item if found to be satisfactory or is operating within established limits. (Write in observed values where determined). Unmarked items must be corrected before using instrument.

- **DIAGNOSTIC RECORD**
  - DATE AND TIME ____________________
  - DETECTOR
  - PROGRAM
  - SAMPLE CHAMBER ___________________
  - FILTER 1
  - BREATH TUBE ________________________
  - FILTER 2
  - PUMP
  - INTERNAL STANDARD

- **BREATH ANALYZER ACCURACY STANDARDS**
  - SIMULATOR SOLUTION
  - COMPRESSED ETHANOL-GAS MIXTURE
  - STANDARD SUPPLIER __________________ LOT # ______ EXP. DATE ______
  - SIMULATOR TEMP (34°C ± 0.2°C) __________________ SIM. SN ______________ SIM. NIST EXP DATE ______

- **CALIBRATION CHECK** - (ONLY ONE STANDARD IS TO BE USED PER MAINTENANCE REPORT)
  - Run three tests using a standard solution. All three tests must be within ±5% of the standard value and must have a spread of .005 or less. Mark the box corresponding to the standard solution being used.
  - 0.10% STANDARD - MUST READ BETWEEN 0.095% AND 0.105% INCLUSIVE
  - 0.08% STANDARD - MUST READ BETWEEN 0.076% AND 0.084% INCLUSIVE
  - 0.04% STANDARD - MUST READ BETWEEN 0.038% AND 0.042% INCLUSIVE

  TEST 1:    TEST 2:    TEST 3:

- **PERFORM R.F.I. TEST**

**INDICATE THE NUMBER OF BREATH TEST IN THE FOLLOWING RANGES SINCE THE LAST MAINTENANCE REPORT:**

<table>
<thead>
<tr>
<th>REFUSALS</th>
<th>0-.04</th>
<th>.05-.09</th>
<th>.10-.14</th>
<th>.15-.19</th>
<th>OVER .19</th>
</tr>
</thead>
</table>

LIST ANY NEW PARTS AND DESCRIBE ANY ALTERATION OR MODIFICATION THAT WAS MADE TO RESTORE THE INSTRUMENT TO OPERATE SATISFACTORILY AND WITHIN ESTABLISHED LIMITS (USE OTHER SIDE IF NECESSARY)

**INSPECTING OFFICER**

<table>
<thead>
<tr>
<th>SIGNATURE</th>
<th>PRINT FULL NAME</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>TYPE II PERMIT NUMBER</th>
<th>EXPIRATION DATE</th>
<th>TELEPHONE NUMBER</th>
</tr>
</thead>
</table>

**RETURN COMPLETED REPORT TO THE** Breath Alcohol Program, Missouri Department of Health and Senior Services by mail, fax, or email