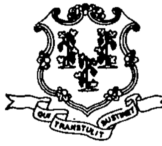
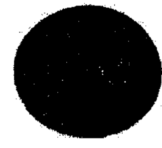


STATE OF CONNECTICUT

Department of Correction

Elevator Service Report Form

(Revised 12/2/13)



Instructions: Please complete for all visits - PLEASE PRINT
Please review accuracy and completeness before signing.

Please fax to Purchasing @ 860-692-6879 within 24 hours. Please keep ORIGINAL.

Vendor Name:		Running PO No:	
Facility Name:			
Facility Address:		Service Type: PM ☐	Service Type: Call Back ☐

Elevator Make:	Model No:	Serial No:	Pass	DW	FRT	Escalator	

Job Site Situation:

Description of Service:

List of Stock Materials Used: Elevator running upon departure? Y ☐ N ☐

Manufacturer:	Mfg Part No:	Item Description:	Qty:	Price:	Amount:

				Reg Rate:	OT Rate:	
Tech 1:	Service Date:	Arrive Time:	Depart Time:	Reg Hrs:	OT Hrs:	Total Hrs:
Tech 2:	Service Date:	Arrive Time:	Depart Time:	Reg Hrs:	OT Hrs:	Total Hrs:

Requester: Please check ONE of the following:

Service performed was normal preventative maintenance (PM) Y____ N _____

Repair service above was required due to normal equipment wear & tear Y____ N _____
Explanation : (Use reverse if necessary)

Repair service above was required due to agency misuse of equipment Y____ N _____
Explanation : (Use reverse if necessary)

Technician 1 Name (Please print)	Technican Signature	Date
Technician 2 Name (Please print)	Technican Signature	Date
Agency Rep Name (Please print)	Agency Representative Signature	Date

Facility - Original Purchasing - Fax Copy Vendor Copy