

FOR REFERENCE ONLY – DO NOT USE

STATE WATER RESOURCES CONTROL BOARD
DIVISION OF DRINKING WATER
WATER TREATMENT DEVICE REGISTRATION PROGRAM
Email address: **WTDevices@waterboards.ca.gov**
Mailing address: **SWRCB Accounting Office**
P.O. Box 1888
Sacramento, CA 95812-1888



Application for Registration - Water Treatment Device Model

Name of Manufacturer: _____

Model Name (*one model per application*): _____

Contact Person for this Application: _____

Address: _____

Phone: _____ Email: _____

Contact Person for the Future Correspondence: _____

Address: _____

Phone: _____ Email: _____

Completed application must include:

1. This original signed application form for each model. Please submit with payment & email electronic copy. The mailing address is listed at the top of this page.
2. An electronic copy of the Performance Data Sheet (Please refer to the manufacturer's webpage for the details).
3. Payment of the registration fee of \$350 for each separate model. Make checks payable to "SWRCB- Device Program Fees Fund Number 0129".
4. Verification of certification by Independent Certifying Organization (electronic copy of listing or equivalent).
5. Send electronic copies of documents to: WTDevices@waterboards.ca.gov.

I certify that the information submitted for this registration is accurate and completed. I agree to inform the State Water Resources Control Board, Devices program of changes to this model that have an impact on the ability of the model to achieve stated contaminant reduction claims.

Name: _____ Title: _____

Signature of Authorized Representative: _____ Date: _____

FOR REFERENCE ONLY – DO NOT USE

FOR REFERENCE ONLY – DO NOT USE

Details on the Water Treatment Model Device

Name of Manufacturer: _____
Model Name: _____
Name of the Certifying Organization: _____
Contact Person from the Certifying Organization: _____
Title: _____
Phone: _____ Email: _____
Certification Effective Date: _____ Certification Expiration Date: _____

Please provide answers to the following questions regarding the status of the certification for this model:

1. Please indicate what health claims are made by this device:

Microbiological: ___ Cysts ___ Turbidity ___ Other

Inorganic: ___ Asbestos ___ Arsenic 3 ___ Arsenic 5 ___ Barium ___ Cadmium
___ Chromium 3 ___ Chromium 6 ___ Copper ___ Fluoride ___ Lead
___ Mercury ___ Nitrate ___ Nitrite ___ Radium226/228 ___ Selenium ___ Other

Organic: ___ Atrazine ___ Benzene ___ Carbon Tetrachloride ___ Lindane ___ MTBE
___ Simazine ___ Tetrachloroethylene ___ Trihalomethanes ___ VOCs by chloroform surrogate ___ Other

2. Flow rate and capacity of filter cartridge (*circle units*): _____ gpm/gpd _____ gallons/liters

3. Type of technology (*check as many as apply to the device*): ___ GAC ___ Reverse
Osmosis ___ Ion Exchange ___ Cationic Water Softener ___ Ozone ___ Ultraviolet
___ Distillation ___ Mechanical Filtration ___ Carbon Block ___ Other

If checked Other, please provide a short description: _____

4. Cartridges: Does the device has alternate filter cartridges with different claims or capacities? ___ If yes, please list here for separate registration: _____

Please certify by your signature that the above information submitted is correct and true and you are aware and accept that SWRCB may request from your certifying organization that they provide us with actual performance testing data in response to significant concerns that may arise regarding the performance of the device or the ability of the device to meet stated health claims.

Name: _____ Title: _____

Signature of Authorized Representative: _____ Date: _____

FOR REFERENCE ONLY – DO NOT USE