

INSPECTION AND TESTING FORM

Date: _____ Time: _____

SERVICE ORGANIZATION

Name: _____
 Address: _____
 Representative: _____
 License No.: _____
 Telephone: _____

PROPERTY NAME (USER)

Name: _____
 Address: _____
 Owner Contact: _____
 Telephone: _____

MONITORING ENTITY

Contact: _____
 Telephone: _____
 Monitoring Account Ref. No.: _____

APPROVING AGENCY

Contact: _____
 Telephone: _____

TYPE TRANSMISSION

McCulloh Multiplex Digital
 Reverse Priority RF
 Other (Specify) _____

SERVICE

Weekly Monthly Quarterly
 Semiannually Annually
 Other (Specify) _____

Control Unit Manufacturer: _____
 Model No.: _____
 Circuit Styles: _____
 Number of Circuits: _____
 Software Rev.: _____
 Last Date System Had Any Service Performed: _____
 Last Date That Any Software or Configuration Was Revised: _____

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested	
_____	_____	_____	Manual Fire Alarm Boxes
_____	_____	_____	Ion Detectors
_____	_____	_____	Photo Detectors
_____	_____	_____	Duct Detectors
_____	_____	_____	Heat Detectors
_____	_____	_____	Waterflow Switches
_____	_____	_____	Supervisory Switches
_____	_____	_____	Other (Specify): _____

Alarm verification feature is disabled enabled

ALARM NOTIFICATION APPLIANCES AND CIRCUIT INFORMATION

Quantity of Appliances Installed	Circuit Style	Quantity of Appliances Tested	
_____	_____	_____	Bells
_____	_____	_____	Horns
_____	_____	_____	Chimes
_____	_____	_____	Strobes
_____	_____	_____	Speakers
_____	_____	_____	Other (Specify): _____

No. of alarm notification appliance circuits: _____

Are circuits monitored for integrity? Yes No

SUPERVISORY SIGNAL-INITIATING DEVICES AND CIRCUIT INFORMATION

Quantity of Devices Installed	Circuit Style	Quantity of Devices Tested	
_____	_____	_____	Building Temp.
_____	_____	_____	Site Water Temp.
_____	_____	_____	Site Water Level
_____	_____	_____	Fire Pump Power
_____	_____	_____	Fire Pump Running
_____	_____	_____	Fire Pump Auto Position
_____	_____	_____	Fire Pump or Pump Controller Trouble
_____	_____	_____	Fire Pump Running
_____	_____	_____	Generator in Auto Position
_____	_____	_____	Generator or Controller Trouble
_____	_____	_____	Switch Transfer
_____	_____	_____	Generator Engine Running
_____	_____	_____	Other (Specify): _____

SIGNALING LINE CIRCUITS

Quantity and style of signaling line circuits connected to system (*see NFPA 72[®], Table 6.6.1*):

Quantity _____ Style(s) _____

SYSTEM POWER SUPPLIES

(a) Primary (Main): Nominal Voltage _____ Amps _____

Overcurrent Protection: Type _____ Amps _____

Location (of Primary Supply Panelboard): _____

Disconnecting Means Location: _____

(b) Secondary (Standby):

Storage Battery: Amp-Hr Rating _____

Calculated capacity in _____ Amp-Hrs to operate system for _____ hours

Engine-driven generator dedicated to fire alarm system: _____

Location of fuel storage: _____

TYPE BATTERY

Dry Cell Lead-Acid

Nickel-Cadmium Other (Specify): _____

Sealed Lead Acid

(c) Emergency or standby system used as a backup to primary power supply, instead of using a secondary power supply:

_____ Emergency system described in *NFPA 70*[®], Article 700

_____ Legally required standby described in *NFPA 70*[®], Article 701

_____ Optional standby system described in *NFPA 70*[®], Article 702, which also meets the performance requirements of Article 700 or 701

PRIOR TO ANY TESTING

NOTIFICATIONS ARE MADE	Yes	No	Who	Time
Monitoring Entity	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Building Occupants	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Building Management	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
AHJ Notified of Any Impairments	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

SYSTEM TESTS AND INSPECTIONS

TYPE	Visual	Functional	Comments
Control Unit	<input type="checkbox"/>	<input type="checkbox"/>	_____
Interface Equipment	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lamps/LEDs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fuses	<input type="checkbox"/>	<input type="checkbox"/>	_____
Primary Power Supply	<input type="checkbox"/>	<input type="checkbox"/>	_____
Trouble Signals	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disconnect Switches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ground-Fault Monitoring	<input type="checkbox"/>	<input type="checkbox"/>	_____

SECONDARY POWER

TYPE	Visual	Functional	Comments
Battery Condition	<input type="checkbox"/>		_____
Load Voltage		<input type="checkbox"/>	_____
Discharge Test		<input type="checkbox"/>	_____
Charger Test		<input type="checkbox"/>	_____
Specific Gravity		<input type="checkbox"/>	_____
TRANSIENT SUPPRESSORS	<input type="checkbox"/>		_____
REMOTE ANNUNCIATORS	<input type="checkbox"/>	<input type="checkbox"/>	_____
NOTIFICATION APPLIANCES			
Audible	<input type="checkbox"/>	<input type="checkbox"/>	_____
Visible	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speakers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Voice Clarity		<input type="checkbox"/>	_____

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Measured Setting	Pass	Fail
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Comments:

EMERGENCY COMMUNICATIONS EQUIPMENT

	Visual	Functional	Comments
Phone Set	<input type="checkbox"/>	<input type="checkbox"/>	_____
Phone Jacks	<input type="checkbox"/>	<input type="checkbox"/>	_____
Off-Hook Indicator	<input type="checkbox"/>	<input type="checkbox"/>	_____
Amplifier(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tone Generator(s)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Call-in Signal	<input type="checkbox"/>	<input type="checkbox"/>	_____
System Performance	<input type="checkbox"/>	<input type="checkbox"/>	_____

COMBINATION SYSTEMS

	Visual	Device Operation	Simulated Operation
Fire Extinguisher Monitoring Device/System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carbon Monoxide Detector/System	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

INTERFACE EQUIPMENT

(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SPECIAL HAZARD SYSTEMS

(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Special Procedures:

Comments:

SUPERVISING STATION MONITORING

	Yes	No	Time	Comments
Alarm Signal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Alarm Restoration	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Trouble Signal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Trouble Signal Restoration	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Supervisory Signal	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Supervisory Restoration	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

NOTIFICATIONS THAT TESTING IS COMPLETE

	Yes	No	Who	Time
Building Management	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Monitoring Agency	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Building Occupants	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other (Specify)	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

The following did not operate correctly:

System restored to normal operation:

Date: _____ Time: _____

THIS TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS

Name of Inspector: _____ Date: _____ Time: _____

Signature: _____

Name of Owner or Representative: _____ Date: _____ Time: _____

Signature: _____