

Name _____

Address _____

Phone _____

Here

Confidence Test Report

(253) 983-4583 Confidence testing questions

(253) 582-7912 (fax)

SPRAY BOOTH SYSTEM

(One System per Report)

Certification Given		
RED <input type="checkbox"/>	YELLOW <input type="checkbox"/>	WHITE <input type="checkbox"/>

CONFIDENCE TEST <input type="checkbox"/>	REPAIRS <input type="checkbox"/>
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Occupancy Address: _____	Occupancy Name: _____
Building Owner: _____	Phone Number: _____
Responsible Person: _____	Phone Number: _____
Building Owner Address: _____	
Date of Inspection: _____	Inspection Frequency/Type: Annual
Testers Name (Please Print): _____	
Central station monitoring? Yes <input type="checkbox"/> No <input type="checkbox"/>	Monitoring Company Name: _____
Primary Component: _____	System Make: _____
System Model: _____	System Size: _____
System Location: _____	Identification Number: _____

PROBLEMS FOUND: (If additional room is needed, please add a separate sheet)

CORRECTIONS MADE: Date Corrected: _____ Corrected By: _____
 (If additional room is needed, please add a separate sheet)

This certifies that this fire and life safety system has been properly inspected for reliability to cover the items listed in this report and is consistent with National Fire Protection Association standards, and that discrepancies are noted and have been reported to the building Owner/Manager for corrective action.

Signature of Tester: _____ Phone # _____

Testing Agency: _____

Mailing Address: _____

Building Representative (signature) _____

The items on the checklists below shall be inspected and tested. This list does not constitute all of the required inspecting and testing of the fire and life safety system. Refer to the NFPA for inspecting and testing requirements.

System Functionality

Trouble signal with AC power off?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
System operates properly on battery backup?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Battery voltage (no load) _____ volts		
Battery voltage (full load) _____ volts (signals operating)		
Charge circuit voltage _____ volts		
System operates properly on standby power?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
All signals operate on AC power?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Number of initiating circuits _____		
Number of signal circuits _____		
Does system meet audibility standards?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
All circuits checked for electrical supervision?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
All auxiliary equipment operates (Elevators, fans, dampers)?	N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Key to panel available?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Operating instructions at panel?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Elevator call down functions properly?	N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Test record posted at panel?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Hoses checked for damage?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Are warning signs installed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Was a signal received at the Central Station monitoring company?	N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was time delay tested for operation?	Yes <input type="checkbox"/>	No <input type="checkbox"/>

System Devices	Total Number of Units in Building	Total Number Units Tested	Test Results Acceptable
Bells, Horns, Chimes	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Voice Speakers (Voice Clarity)	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Smoke Detectors	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Heat Detectors	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Duct Detectors	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Visual Alarm Devices	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Manual Pull Stations	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Automatic Door Unlocks	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Automatic Door Release	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>

Communication Equipment	Total Number of Units in Building	Total Number Units Tested	Test Results Acceptable
Phone Sets	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Phone Jacks	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
Call-in Signal	_____	_____	N/A <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>