

Washington Township Fire District
Bureau of Fire Prevention
PO Box 8176
Turnersville, NJ 08012
(856) 863-4000 – Fax (856) 589-0239

ALARM SYSTEM
INSPECTION AND TESTING FORM

SERVICE ORGANIZATION

Name: _____
Address: _____
Representative: _____
License #: _____
Telephone: _____

Date: _____
Time: _____

MONITORING ENTITY

Contact: _____
Telephone: _____
Monitoring Account Ref #: _____

PROPERTY NAME (USER)

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

TYPE TRANSMISSION

- McCulloh
 - Multiplex
 - Digital
 - Reverse Priority
 - RF
 - Other (Specify)
- _____
- _____

APPROVING AGENCY

Contact: _____
Telephone: _____

SERVICE

- Weekly
- Monthly
- Quarterly
- Semiannually
- Annually
- Other (Specify)

Panel Manufacturer: _____
Circuit Styles: _____
Software Rev: _____
Last Date System Had Any Service Performed: _____
Last Date that any Software or configuration was Revised: _____

Model #: _____

ALARM-INITIATING DEVICES AND CIRCUIT INFORMATION

QTY. OF

CIRCUIT STYLE

_____	_____	Manual Station
_____	_____	Ion Detectors
_____	_____	Photo Detectors
_____	_____	Duct Detectors
_____	_____	Heat Detectors
_____	_____	Waterflow Switches
_____	_____	Supervisory Switches
_____	_____	Other (Specify) _____

PRIOR TO ANY TEST

NOTIFICATIONS ARE MADE:	YES	NO	WHO	TIME
Monitoring entity	()	()	_____	_____
Building Occupants	()	()	_____	_____
Building Management	()	()	_____	_____
Other (Specify)	()	()	_____	_____
AHJ Notified	()	()	_____	_____

SYSTEM TESTS AND INSPECTIONS

TYPE	VISUAL	FUNCTIONAL	COMMENTS
Control Panel	()	()	_____
Interface Eq.	()	()	_____
Lams/Leds	()	()	_____
Fuses	()	()	_____
Primary Power Supply	()	()	_____
Trouble Signals	()	()	_____
Disconnect Switches	()	()	_____
Ground Fault Monitoring	()	()	_____

SECONDARY POWER

TYPE	VISUAL	FUNCTIONAL	COMMENTS
Battery Condition	()		_____
Load Voltage		()	_____
Discharge Test		()	_____
Charger Test		()	_____
Specific Gravity		()	_____
Transient Suppressors	()		_____
Remote Annunciators	()	()	_____

NOTIFICATION APPLIANCES

	VISUAL	FUNCTIONAL	COMMENTS
Audible	()	()	_____
Visual	()	()	_____
Speakers	()	()	_____
Voice Clarity	()		_____

INITIATING AND SUPERVISORY DEVICE TESTS AND INSPECTIONS

Loc. & S/N	Device Type	Visual Check	Functional Test	Factory Setting	Meas. Setting	Pass	Fail
_____	_____	()	()	_____	_____	()	()
_____	_____	()	()	_____	_____	()	()
_____	_____	()	()	_____	_____	()	()
_____	_____	()	()	_____	_____	()	()
_____	_____	()	()	_____	_____	()	()

Comments: _____

EMERGENCY COMMUNICATIONS EQUIPMENT

	VISUAL	FUNTIONAL	COMMENTS
Phone Set	()	()	_____
Phone Jacks	()	()	_____
Off-Hook Indicator	()	()	_____
Amplifier(s)	()	()	_____
Tone Generator(s)	()	()	_____
Call-In Signal	()	()	_____
System Performance	()	()	_____

	VISUAL	DEVICE FUNTIONAL	SIMULATED COMMENTS
Interface Equipment	()	()	()
(Specify)	()	()	()
(Specify)	()	()	()
(Specify)	()	()	()
Special Hazard Systems	()	()	()
(Specify)	()	()	()
(Specify)	()	()	()
(Specify)	()	()	()

Special Procedures: _____

Comments: _____

ON/OFF PREMISES MONITORING:	YES	NO	TIME	COMMENTS
Alarm Signal	()	()	_____	
Alarm Restoral	()	()	_____	
Trouble Signal	()	()	_____	
Supervisory Signal	()	()	_____	
Supervisory Restoral	()	()	_____	
NOTIFICATIONS THAT TESTING IS COMPLETE	YES	NO	WHO	TIME
Building Management	()	()	_____	
Monitoring Agency	()	()	_____	
Building Occupants	()	()	_____	
Other (Specify)	()	()	_____	

THE FOLLOWING DID NOT OPERATE CORRECTLY: _____

SYSTEM RESTORED TO NORMAL OPERATIONS: **DATE** _____ **TIME** _____

THE TESTING WAS PERFORMED IN ACCORDANCE WITH APPLICABLE NFPA STANDARDS.

Name of Inspector: _____ Date _____ Time _____ Signature _____

Name of Owner Or Representative: _____

Date _____ Time _____ Signature: _____