

DEVICE TEST FORM
FAX# 248-624-1616

DUE DATE:

Facility Name:
Site address:
Site City:

INITIAL Date of Test: _____

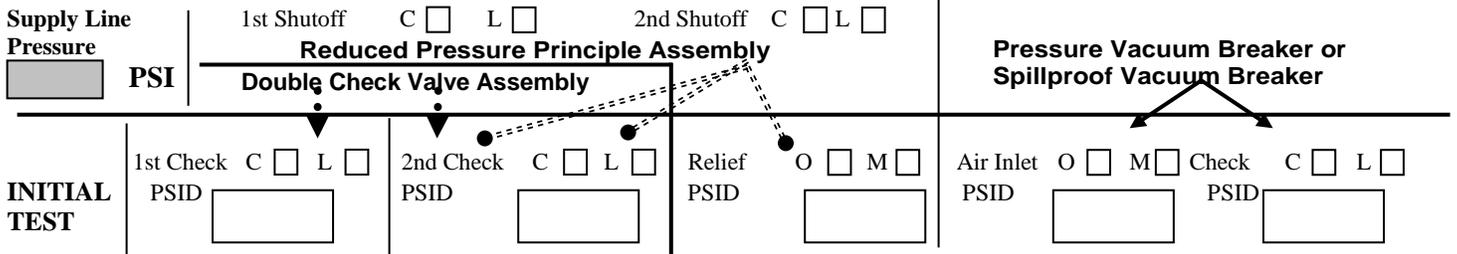
FINAL Date of Test (after repairs): _____

SECTION 1. DEVICE INFORMATION

Type / MFG/ Model / Size: _____ **Serial #:** _____

Use & Location: _____

SECTION 2. INITIAL TEST

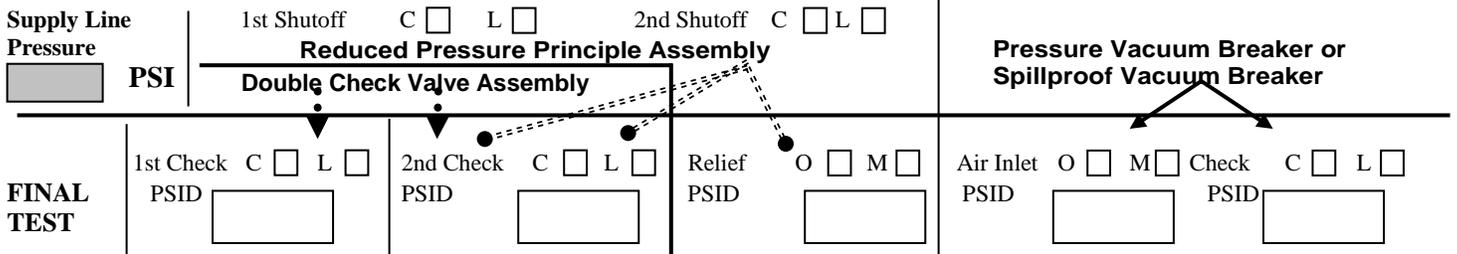


Pass Fail ****NOTE: ALL FAILED TESTS ARE REQUIRED TO BE SUBMITTED**

SECTION 3. REPAIRS

List any repairs made below and reason for FAIL (if applicable):

SECTION 4. FINAL TEST (after repairs)



Pass Fail

SECTION 5. Certification

On this date the above device was tested per applicable codes and the required performance standards.

Tester Name: _____ Tester MPMCA/ASSE Certification #: _____ Expires: _____

Testing Firm: _____ Testing Firm E-mail address: _____

Testing Firm Mailing Address: _____

Testing Firm Phone #: _____ Testing Firm Fax #: _____

Tester Signature: _____ Date of Form Completion: _____

SECTION 6. Test Gauge

Make: _____ Model: _____ Serial #: _____

Date of Last Calibration: _____

*Copy included of most recent test gauge calibration

****all incomplete forms will be returned to the tester***