

# RESIDENTIAL MECHANICAL VENTILATION RECORD

*For Certification of Design and Performance of Residential Ventilation Systems (CSA F326)*

**W2**

<b>A</b>	HEATING SYSTEM/ COMBUSTION APPLIANCES	<input type="checkbox"/> Forced Air <input type="checkbox"/> Non Forced air <input type="checkbox"/> Electric <input type="checkbox"/> Gas <input type="checkbox"/> Oil <input type="checkbox"/> Other		Roll #:	Permit #:	LOCATION <b>H</b>				
		No Combustion Appliances <i>No Depressurization Limit</i> Solid Fuel (including Fireplaces) <i>5 Pa. Depressurization Limit</i> Direct Vent (sealed combustion) <i>No Depressurization Limit</i> Positive Venting Induced Draft _____ <i>5 Pa. Depress. Limit</i> Natural Draft or B-Vent Atmospheric <i>5 Pa. depressurization limit</i> Lowest Depressurization Limit _____ Pa.		Lot & Plan: Civic address: Name: _____ House ID#: _____ Address: _____ City: _____ P.C. _____ Phone: _____ Fax: _____ Email Address: _____			BUILDER <b>I</b>			
		<b>B</b>	EXHAUST EQUIPMENT	<input type="checkbox"/> Clothes Dryer(s) (150 cfm default) <input type="checkbox"/> Downdraft Cook Top (220 cfm default) <input type="checkbox"/> Other (exhaust) (over 150 cfm)				Name: _____ HRAI #: Address: _____ City: _____ P.C. _____ Phone: _____ Fax: _____		DESIGNER <b>J</b>
				Depressurization test/Calc. Required?    Yes    No				Email Address: _____ Other # _____ I certify this ventilation system design to be in accordance with: <input type="checkbox"/> CSA F326 M-91 <input type="checkbox"/> R-2000 Signature: _____ Date: _____		
<b>C</b>	TOTAL VENTILATION CAPACITY (TVC)	Bsmt & Master Bedroom _____ @ 20 cfm _____ cfm Other Bedrooms _____ @ 10 cfm _____ cfm Bathrooms & Kitchens _____ @ 10 cfm _____ cfm Other Hab. Rooms _____ @ 10 cfm _____ cfm Total Ventilation Capacity (TVC) _____ cfm		Controls Functioning <input type="checkbox"/> Fans operating and clean Filters Clean <input type="checkbox"/> Flow measuring stations Dampers Accessible <input type="checkbox"/> Insulated ducts sealed Drain loop and connection <input type="checkbox"/> Label supply/exhaust hood Distribution to all habitable rooms (non forced air) Forced air system <input type="checkbox"/> Continuous mode <input type="checkbox"/> Interlocked Kitchen intake grease filter <input type="checkbox"/> Kitchen exh. 40" to range Exhaust 4" above grade <input type="checkbox"/> Supply 18" above grade Supply intake 6' from exhaust ( <i>recommended</i> ) Supply intake 3' from other exhaust		INSTALLATION CHECKLIST <b>K</b>				
		<b>D</b>	EXHAUST CAPACITY	Continuous Minimum Continuous Exhaust Kitchen(s) _____ @ 60 cfm = _____ cfm Bathroom(s) _____ @ 20 cfm = _____ cfm Total _____ cfm			TVC system SUPPLY airflow measured _____ cfm High    _____ cfm Low TVC system EXHAUST airflow measured _____ cfm High    _____ cfm Low			
Intermittent Minimum Intermittent Exhaust Kitchen(s) _____ @ 100 cfm = _____ cfm Bathroom(s) _____ @ 50 cfm = _____ cfm Total _____ cfm										
<b>E</b> <b>F</b>	TVC SYSTEM	Location: _____ Manufacturer/Model: _____ HVI rated Design Airflow _____ cfm high    _____ cfm low HRV/ERV _____ % Sensible Efficiency @ 0°C    _____ watts HRV/ERV _____ % Sensible Efficiency @ -25°C    _____ watts		Name: _____ HRAI #: Address: _____ City: _____ P.C. _____ Phone: _____ Fax: _____ Email Address: _____		MEASURED TVC SYSTEMS <b>L</b>				
		<b>G</b>	ADDITIONAL (exhaust)EQUIPMENT	1 Location: _____ cfm    _____ Sones Manufacturer/Model: _____ TVC HVI			I certify this ventilation system install to be in accordance with: CSA F326 M-91 R-2000 Signature: _____ Date: _____		INSTALLER <b>M</b>	
2 Location: _____ cfm    _____ Sones Manufacturer/Model: _____ TVC HVI										
3 Location: _____ cfm    _____ Sones Manufacturer/Model: _____ TVC HVI										
4 Location: _____ cfm    _____ Sones Manufacturer/Model: _____ TVC HVI										

Prepared By:	HRAI #:	Job Name:
Signature:	Date:	Job #:      Official Use:

