



Smoke Control Systems (SCS) Report Cover Sheet and Summary

Date of Report Submission: _____

Building Information

Building Name:	
Building Address:	
Job Number:	

Building Contact Information

Primary Contact Name:	
Primary Contact Title:	
Primary Contact Email:	
Primary Contact Phone:	

Scope of Work: _____

Referenced Code or Standard: _____

Initial Test Results

Test Date(s)
Test Description
Initial Test Results

Repairs and Adjustments

Equipment	Location	Repair or Adjustment	Date

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Final Test:

Test Date(s)
Test Description
Final Test Results

Technician

Name:		
Email:		
Phone:		
Employer		
Employer Address:		
ICB SCS Technician Certification Number:		
Signature/Stamp		

Supervisor

Name:		
Email:		
Phone:		
Employer		
Employer Address:		
ICB SCS Supervisor Certification Number:		
Signature/Stamp		

Contractor

Name:		
Email:		
Phone:		
Address:		
ICB SCS Contractor Certification Number:		