



Hospital Service Notification Form

Preventative Maintenance? Yes No

REASON FOR SERVICE: _____

DESCRIPTION OF SERVICE: _____

PARTS REPLACED:

Part Description	Qty	Bunnell P/N	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

TESTS PERFORMED (if any)

- RECALIBRATION
- SELF-TEST
- ROUTINE SERVICE VERIFICATION PROC
- OTHER (please describe)

HOSPITAL INFORMATION:

Hospital Name: _____
 Address: _____
 City, State, Zip: _____
 TEL/FAX: TEL _____ FAX: _____

LIFE PULSE VENTILATOR CALIBRATION LOG

S/N: _____ Hour Meter Reading: _____

CALIBRATION									
VENTILATOR					HUMIDIFIER				
Airway Pressure cm H ₂ O		Servo Pressure PSI (kPa)		Purge Press. PSI (kPa)	IRQ Hz	Cartridge Temp C		Circuit Temp C	
@0	@80	@0	@30			Low	High	Low	High
.109	80.9	.009	30.9	6.5	20.4	25.2	48.6	25.2	48.6
.091	79.1	.001	(213.1) 29.1 (200.6)	(44.8) 5.5 (37.9)	19.6	24.8	48.2	24.8	48.2
Before									
After									
Electrical Integrity and Voltage Test									
Ground Resistance 200mΩ Max	Current Leakage 100μA Max	Voltage Level (Driver Board)							
		Max	Min	P3-2	P3-4	P3-5	P3-9	P3-6	P3-10
				-14.3	5.1	15.7	12.4	12.4	42.5
				-15.7	4.9	14.3	11.0	11.0	39.0

Date of Service: _____



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PATIENT BOX MODEL 312 CALIBRATION LOG

		BEFORE Calibration			AFTER Calibration			S/N _____	
		Crack Pressure lbs Force/ PSI (kPa)	Transducer Volts		Crack Pressure lbs Force/ PSI (kPa)	Transducer Volts			
		Tolerance (√ r X)	@0.0 cm H ₂ O	@100.0 cm H ₂ O	2.4 / 27.5 PSI (189.6) Minimum	@0.0 cm H ₂ O	@100.0 cm H ₂ O	Performed	
Max	NA	NA	NA	NA	NA	10.015	-9.985	By	Date
Min	2.4 lbs/27.5 (189.6)	NA	NA	2.4 lbs/27.5 (189.6)	9.985	-10.015			
		<input type="checkbox"/> In <input type="checkbox"/> Out			<input type="checkbox"/> In <input type="checkbox"/> Out				

Date of Service: _____

Technician's Name: _____

FAX COMPLETED & SIGNED FORM TO: 801-467-0867

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