

VENTILATION DESIGN SUMMARY WORKSHEET

LOCATION OF INSTALLATION

Lot #:	Plan #:
Township:	
Roll #:	Permit #:
Address:	

BUILDER

Name:	
Address:	
City:	Postal Code:
Phone:	Fax:

INSTALLATION CONTRACTOR

Name:	
Address:	
City:	Postal Code:
Phone:	Fax:

COMBUSTION APPLIANCES 9.32.3.1 (1)

<input type="checkbox"/>	a) Direct Vent (sealed combustion) only
<input type="checkbox"/>	b) Positive Venting induced draft (except fireplaces)
<input type="checkbox"/>	c) Natural draft, B-Vent or induced draft fireplace
<input type="checkbox"/>	d) Solid Fuel (including fireplaces)
<input type="checkbox"/>	e) No Combustion Appliances

HEATING SYSTEM

<input type="checkbox"/>	Forced Air	<input type="checkbox"/>	Non Forced Air
<input type="checkbox"/>	Electric Space Heating		

HOUSE TYPE 9.23.3.1 (2)

<input type="checkbox"/>	I Type a) or b) appliances only, no solid fuel
<input type="checkbox"/>	II Type 1 except with solid fuel (including fireplaces)
<input type="checkbox"/>	III Any Type of c) appliance
<input type="checkbox"/>	IV Type I or II with electric space heat
<input type="checkbox"/>	Other: Type I, II or IV no forced air

SYSTEM DESIGN OPTION

<input type="checkbox"/>	1 Exhaust Only / Forced Air System
<input type="checkbox"/>	2 HRV with Exhaust Ducts / Forced Air System
<input type="checkbox"/>	3 HRV Simplified Connection to Forced Air System
<input type="checkbox"/>	4 HRV - Full Ducting - not coupled with FA System
<input type="checkbox"/>	Part 6 Design

TOTAL VENTILATION CAPACITY 9.32.3.3

Bsmt & Master Bdrm:	@ 20 cfm =	0 cfm
Other Bedrooms :	@ 10 cfm =	0 cfm
Bathrooms & Kitchen:	@ 10 cfm =	0 cfm
Other Rooms:	@ 10 cfm =	0 cfm
TOTAL :		0 cfm

PRINCIPAL VENTILATION CAPACITY 9.32.3.4 (1)

Master Bedroom:	@ 30 cfm =	0 cfm
Other Bedrooms :	@ 15 cfm =	0 cfm
TOTAL PRINCIPAL VENTILATION:		0 cfm

PRINCIPAL EXHAUST FAN CAPACITY

Model:	Location:
_____ cfm	_____ Sones <input type="checkbox"/> HVI

HEAT RECOVERY VENTILATOR

Model:	
_____ cfm High	_____ cfm Low
_____ % Sensible Efficiency @ -25°C	<input type="checkbox"/> HVI

SUPPLEMENTAL VENTILATION CAPACITY

Total Ventilation Capacity	_____ cfm
<i>Less</i> Principal Ventilation Capacity	_____ cfm
<i>required</i> Supplemental Ventilation Capacity	_____ cfm

SUPPLEMENTAL FANS 9.32.3.5

LOCATION	CFM	MODEL	SONES	HVI

DESIGNER CERTIFICATION

I hereby certify that this ventilation system has been designed in accordance with the Ontario Building Code.
NAME: _____
SIGNATURE: _____
HRAI#: _____
Date: _____