

Station Name	Area	District	Anniversary Month
Line or System Supplied by Facility (See Note 1 Below)			(See Note 2 Below)

Part 1 – To Be Completed Annually

This capacity check is for the year	Yes												No											
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
1. Was capacity reviewed for the previous year? If No, complete Part 2 of Annual Capacity Review for Compressor Stations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
2. Did previous review show that relief valve(s) had adequate capacity? If No, complete Part 2 of Annual Capacity Review for Compressor Stations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
3. Have there been any changes to the compressor(s) at this station, to pressure conditions (either inlet or outlet), to load conditions, or to supply conditions which could affect the ability of the relief valve(s) to limit the pressure to the maximum permitted by Paragraphs 192.169 and 192.201 of 49 CFR 192?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
* If the answer if Yes, complete Part 2 of Annual Capacity Review for Compressor Stations. ** If answers to Items 1 and 2 were Yes and Item 3 was No, check Yes on Item 4.																								
4. Relief valve(s) at this station have adequate capacity. If No, complete Part 3 of Annual Capacity Review for Compressor Stations.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Verified By (Place initials in the appropriate box.)																								
Date (Put date verified in the appropriate box.)																								
Approved By (Place initials in the appropriate box.)																								
Date (Put date approved in the appropriate box.)																								

Notes:

- If there are compression facilities at the station supplying more than one line or system, perform a separate review for the overpressure protection devices for each line or system.
- All pressure relief devices shall be inspected, tested, and the capacity reviewed at intervals not exceeding 15 months, but at least once each calendar year. Furthermore, in addition to the annual capacity testing, the capacity of the relief devices shall be verified immediately when changes are made which could affect the ability of the relief device to protect the connected systems.
- The **Verified By** box is usually initiated by a technician or an M&C mechanic. The **Approved By** box is usually initiated by an engineer or operating supervisor/superintendent.

RETAIN THIS DOCUMENT AS A PERMANENT RECORD FOR THE LIFE OF THE FACILITY.

CAPACITY REVIEW OF RELIEF DEVICES AT **COMPRESSOR STATIONS**
AS REQUIRED BY PARAGRAPH 192.731 OF 49 CFR 192 (REFER TO GAS STANDARD H-70)

Part 2 – To be completed only if Part 1 indicates that a complete review is required.

Station Name _____ Date _____
 Division _____ District _____
 Line or System Supplied by Facility (See Note 1 Below) _____
 This Capacity Review Is for the Year _____

1. A complete capacity review was required because:

- a. A capacity review was not preformed in the previous year.
- b. The previous capacity review showed that the relief device capacity was inadequate.
- c. Changes have been made to the equipment at the station, to pressure conditions, to load conditions, or to supply conditions which could affect the ability of the relief valves to limit the pressure to the maximum permitted by 49 CFR 192.

2. Station Pressure Conditions

- P1 – Maximum upstream pressure (MAOP or MOP, if lower) _____ psig
- P2 – Maximum normal suction pressure _____ psig
- P3 – MAOP or MOP downstream of station _____ psig
- P4 – Maximum permissible downstream pressure _____ psig
(See Para 192.169 and Para 192.201)

3. Compressor(s) Supplying Line or System Described Above

Compressor		Max Capacity	Indicate Reference Source for Capacity <i>(Attach calculation sheet)</i>
Operating Diagram Designation	Model	(P1 or P2 in, P4 out)	

4. Maximum Supply Capability

- a. Total capacity of all compressors if installed in parallel. _____ scfh
 Total capacity of series compressor installation with pressure drops adjusted to give maximum flow. _____ scfh
- b. Maximum capacity through station if limited by conditions other than compressor(s). _____ scfh
 State limiting conditions: _____

Note 1 If there are compressor facilities at the station supplying more than one line or system, perform a separate review for the overpressure protection device for each line or system.

CAPACITY REVIEW OF RELIEF DEVICES AT **COMPRESSOR STATIONS**
AS REQUIRED BY PARAGRAPH 192.731 OF 49 CFR 192 (REFER TO GAS STANDARD H-70)

Part 2, continued

Station Name _____ Date _____

5. Relief Capacity Required

Enter either Item 4a or Item 4b, whichever is lower. _____ scfh

6. Relief Device(s) Protecting Line or System Described Above

a.

Relief Device(s)						Maximum Capacity @ P4 (See Note 2)	Capacity Reference
No.	Size	Model	Serial No.	Orifice (Sq. In.)	Maximum Pressure Setting (See Note 2)		

b. Total capacity restrictions from valves, piping, silencers, etc. _____ scfh

Describe _____

c. Relief capacity available. Total of 6(a), less total of 6(b) _____ scfh

7. Adequacy of Relief Capacity

- a. Capacity shown in 6(c) is equal to or greater than relief capacity required (Item 5). Capacity adequate. Complete Item 8 below and answer Question 4 in Part 1. _____
- b. Capacity shown in 6(c) is less than the relief capacity required (Item 5). Capacity not adequate. See Part 3. _____

8. The relief device(s) described above have adequate capacity (See Note 3 Below).

Verified By _____	Approved By _____
Date _____	Date _____

Note 2 Refer to Item 3 and Item 4 of Gas Standard H-70.
Note 3 The **Verified By** box is usually initialed by a GSM&TS or Utility Operations area engineer. The **Approved By** box is usually initialed by the engineering supervisor.

CAPACITY REVIEW OF RELIEF DEVICES AT **COMPRESSOR STATIONS**
AS REQUIRED BY PARAGRAPH 192.731 OF 49 CFR 192 (REFER TO GAS STANDARD H-70)

Part 3 – To be completed only if Part 2 indicates that relief capacity is inadequate.

Station Name _____ Date _____

Division _____ District _____

Line or System Supplied by Facility
(See Note 1 Below) _____

1. Additional relief capacity required (from Part 2, Item 5, less Item 6[c]). _____ scfh

2. Corrective action to be taken:

a. Increase relief capacity (see Item 3, this sheet). _____ scfh

b. Other. Describe _____

3. If relief capacity is increased by adding an additional relief device or replacing the existing relief equipment with a relief device of larger capacity, a copy of the design calculations must be attached to this form.

4. Date capacity was found to be inadequate _____

5. Work to provide adequate overpressure protection completed.

Job No. _____ Completed on _____

Verified By _____	Approved By _____
Date _____	Date _____

Note 1 The **Verified By** box is usually initialed by a GSM&TS or Utility Operations area engineer.
The **Approved By** box is usually initialed by the engineering supervisor.