



CAPACITY REVIEW OF RELIEF DEVICES AT **PRESSURE LIMITING AND REGULATING STATIONS**
 AS REQUIRED BY PARAGRAPHS 192.739(B) AND 192.743 OF 49 CFR 192 (REFER TO NUMBERED DOCUMENT H-70)

GT&D
4/10
FH-70-A

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

Part 1 – To Be Completed Annually

This capacity check is for the year											
1. Was capacity reviewed for the previous year? If No, complete Part 2 of Annual Capacity Review for PLS & Reg Stations.	Yes	<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"/>
	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"/>
2. Did previous review show that relief valve(s) had adequate capacity? If No, complete Part 2 of Annual Capacity Review for PLS & Reg Stations.	Yes	<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"/>
	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"/>
3. Have there been any changes to the equipment 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?	Yes	<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"/>
	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"/>
* If the answer is Yes, complete Part 2 of Annual Capacity Review for PLS & Reg 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 PLS & Reg Stations.	Yes	<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"/>
	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"/>
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:

1. If there are regulating and overpressure 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.
2. 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.
3. The **Verified By** box is usually initialed by a technician or an M&C mechanic.
The **Approved By** box is usually initialed by an engineer or operating supervisor/superintendent.

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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 performed 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 regulated pressure, see Note 10 in Numbered Document H-70) _____ psig
- P2 – MAOP or MOP downstream of station _____ psig
- P3 – Maximum permissible downstream pressure (See Para 192.201) _____ psig

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

Regulating Valve					Wide Open Capacity (@P1 in, P2 out)	Indicate Catalog Reference or Numbered Document for Capacity (Attach calculation sheet)
No.	Size	Model	Inner Valve Size	Field Verified		

If more than one regulator, note if regulators are installed in series or in parallel .

4. Maximum Supply Capability

- a. Capacity of single regulator, if only one regulator. _____ scfh
 Largest capacity of any regulator, if installed in parallel, for stations built before 7-3-72 that have not been rebuilt. _____ scfh
 Total capacity of both regulators, if installed in parallel, for stations built after 7-3-72. _____ scfh
- b. Maximum capacity through station if limited by conditions other than regulators. _____ scfh
 State limiting conditions: _____

Note 1 If there are regulating and overpressure protection 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.



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Part 2, continued

Station Name _____ Date _____

5. Minimum Downstream Load

The minimum load supplied from the line or system being reviewed
under any operating condition or situation. _____ scfh

Note: Unless it can be established that this minimum load will be present
under any operating condition, this load should be considered as zero.

Describe load, if present _____

6. Relief Capacity Required

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

Less Item 5 (if any) _____ scfh

Minimum Relief Capacity Required _____ scfh

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

a. ΔP – Pressure loss resulting from valves, piping, tees, etc. _____ Δ psi

Describe: _____

b.

Relief Device(s)						Maximum Capacity @ P3- Δ P (See Note 2)	Capacity Reference
No.	Size	Model	Inner Valve Size	Field Verified	Maximum Pressure Setting (See Note 2)		

8. Adequacy of Relief Capacity

a. Capacity shown in 7(b) is equal to or greater than relief capacity required (Item 6). Capacity adequate. See Item 9. _____

b. Capacity shown in 7(b) is less than the relief capacity required (Item 6). Capacity not adequate. See Part 3. _____

9. 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 Numbered Document H-70.

Note 3 The **Verified By** box is usually initialed by the responsible gas engineer.
The **Approved By** box is usually initialed by the responsible gas engineer's supervisor.

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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 _____

1. Additional relief capacity required (from Part 2, Item 6, less Item 7[b]). _____ scfh

2. Corrective action to be taken:

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

b. Replace relief equipment with a monitor. _____

c. 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 the responsible gas engineer.
The **Approved By** box is usually initialed by the responsible gas engineer's supervisor.

