

BACKFLOW PREVENTION ASSEMBLY TEST AND MAINTENANCE REPORT

CUSTOMER: _____

STREET ADDRESS: _____

LOCATION OF ASSEMBLY: _____

TYPE OF ASSEMBLY: RP DC PVB SIZE: _____

MANUFACTURER: _____ MODEL: _____ SERIAL# _____ LINE PSI: _____

RELIEF VALVE	CHECK VALVE #1	CHECK VALVE #2	PRESSURE VACUUM BREAKER
OPENED AT: _____ PSID BUFFER _____ PSID DID NOT OPEN <input type="checkbox"/>	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF. PRESSURE ACROSS CHECK VALVE: _____ PSID	<input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT DIFF. PRESSURE ACROSS CHECK VALVE: _____ PSID	AIR INLET OPENED AT: _____ PSID DID NOT OPEN <input type="checkbox"/> CHECK VALVE LEAKED <input type="checkbox"/> HELD AT _____ PSID
<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> RV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>	<input type="checkbox"/> CLEANED ONLY REPLACED: RUBBER KIT <input type="checkbox"/> CV ASSEMBLY <input type="checkbox"/>
OPENED AT: _____ PSID BUFFER _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	<input type="checkbox"/> CLOSED TIGHT _____ PSID	AIR INLET _____ PSID CHECK VALVE _____ PSID
SHUT OFF VALVE # 1 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT		SHUT OFF VALVE # 2 <input type="checkbox"/> LEAKED <input type="checkbox"/> CLOSED TIGHT	

Assembly Passed () Failed ()

NOTE: ALL REPAIRS MUST BE COMPLETED WITHIN 30 DAYS.

REMARKS: _____

TESTER COMPANY NAME: _____ EMAIL: _____ PHONE: _____

INITIAL TEST BY: _____ CERTIFIED TESTER# _____ DATE TESTED: _____

REPAIRED BY: _____ CERTIFIED TESTER# _____ DATE: _____

FINAL TEST BY: _____ CERTIFIED TESTER# _____ DATE: _____

DOMESTIC FIRE LAWN IRRIGATION NEW TEST RECERTIFICATION

TEST KIT: DIFFERENTIAL ELECTRONIC SERIAL# _____ MANUFACTURER: _____ MODEL: _____

TIME OF DAY _____ AM PM SIGNATURE OF TESTER: _____

BY SIGNING THIS REPORT I CERTIFY THAT ALL INFORMATION (TIME, DATE AND ALL PERTINENT DATA) IS ACCURATE AND THAT MY CERTIFICATION AS A TESTER AND MY CALIBRATION OF MY EQUIPMENT ARE CURRENT AND SUBMITTED TO TOWN OF BOONE.