



DEVELOPMENT SERVICES DEPARTMENT

BACKFLOW PREVENTION DEVICE TEST REPORT

Address:			Postal Code
Occupant:	Contact Person/s	Telephone	
		E-mail	
Owner:		Telephone	
Address of Owner			Postal Code
Name of Certified Tester		Tester Certification Number	Telephone
Business Name & Address		Postal Code	E-mail
Make of TEST KIT	Model Number	Serial Number	Calibration Expiry Date m/d/y
Device Location		Purpose of Device	
TEST DATE m/d/y	RP <input type="checkbox"/>	DCVA <input type="checkbox"/>	S/PVB <input type="checkbox"/>
Make	Model	Serial #	SIZE
Initial Test <input type="checkbox"/>	Annual Test <input type="checkbox"/>	PASS <input type="checkbox"/>	FAIL <input type="checkbox"/>
			LINE PRESSURE ____ psi

REDUCED PRESSURE BACKFLOW ASSEMBLY		
Check Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential ____ psi Shut Off Valve #1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed	Check Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential ____ psi Shut off valve #2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed	Relief Valve Opened at ____ psi Pressure differential across check 1 ____ psi Minus the opening of relief valve ____ psi BUFFER (3 psi or grater) ____ psi

DOUBLE CHECK VALVE	PRESSURE VACUUM BREAKER
Check Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential ____ psi Shut Off Valve #1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed	Check Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential ____ psi Shut off valve #2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed
	Air Inlet Valve Opened At ____ psi <input type="checkbox"/> Failed to Open Check Valve <input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight Pressure Differential ____ psi

If assembly fails test, complete this section and note repairs: (If Device replaces an existing device list Serial # of existing device.)

Tester Signature:	Date m/d/y
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