

**BACKFLOW PREVENTION DEVICE TEST REPORT**

Device 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/yy
Device Location		Purpose of Device	
TEST DATE m/d/yy	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

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

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

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Tester Signature: \_\_\_\_\_ Date m/d/yy \_\_\_\_\_