BACKFLOW TEST REPORT

CUSTOMER NAME : _____

STREET ADDRESS: _____

LOCATION OF ASSEMBLY: _____

TYPE OF ASSEMBLY: RP ☐ DC ☐ PVB☐ SIZE : _____

DOMESTIC ☐ FIRE ☐ LAWN IRRIGATION ☐ NEW TEST ☐ RECERTIFICATION TEST ☐

MANUFACTURER: _____ MODEL: _____ SERIAL NO : _____

LINE PRESSURE:_____PSI

RELIEF VALVE	CHECK VALVE #1	CHECK VALVE #2	PRESSURE VACUUM BREAKER
OPENED AT __ . __ PSID DID NOT OPEN ☐ __ . __ BUFFER	☐ LEAKED ☐ CLOSED TIGHT DIFF. PRESSURE ACROSS CHECKVALVE __ . __ PSID	☐ LEAKED ☐ CLOSED TIGHT DIFF. PRESSURE ACROSS CHECKVALVE __ . __ PSID	AIR INLET OPENED AT __ . __ PSID DID NOT OPEN ☐ CHECK VALVE LEAKED ☐ CHECK VALVE HELD AT __ . __ PSID
☐ CLEANED ONLY ☐ REPLACED:RUBBER KIT ☐ RV ASSEMBLY	☐ CLEANED ONLY ☐ REPLACED:RUBBER KIT ☐ RV ASSEMBLY	☐ CLEANED ONLY ☐ REPLACED:RUBBER KIT ☐ RV ASSEMBLY	☐ CLEANED ONLY ☐ REPLACED:RUBBER KIT ☐ RV ASSEMBLY
OPENED AT __ . __ PSID	☐ CLOSED TIGHT DIFF.PRESSURE ACROSS CHECK VALVE __ . __ PSID	☐ CLOSED TIGHT DIFF. PRESSURE ACROSS CHECK VALVE __ . __ PSID	AIR INLET OPENED AT __ . __ PSID CHECK VALVE HELD AT __ . __ PSID
INITIAL TEST: SHUT OFF VALVE #1 ☐ LEAKED ☐ CLOSED TIGHT		FINAL TEST: SHUT OFF VALVE #2 ☐ LEAKED ☐ CLOSED TIGHT	

PASS__ FAIL__

NOTE: ALL REPAIRS MUST BE COMPLETED WITHIN TWENTY ONE DAYS NON-HEALTH HAZARD FOURTEEN DAYS HEALTH HAZARD.

REMARKS: _____

I HEREBY CERTIFY THAT THIS DATA IS ACCURATE AND REFLECTS THE PROPER OPERATION AND MAINTENANCE OF THE ASSEMBLY.

INITIAL TEST BY:_____ CERTIFIED TESTER NO:_____ DATE:_____

REPAIRED BY:_____CERTIFIED TESTER NO:_____ DATE:_____

FINAL TEST BY: _____CERTIFIED TESTER NO:_____ DATE:_____

TEST KIT SERIAL NO. _____ CALIBRATION DATE _____

TIME OF DAY _____ AM ☐ PM ☐ SIGNATURE OF TESTER_____

Return to:

CROSS CONNECTION COORDINATOR
CITY OF WILSON
PO BOX 10
WILSON, NC 27894

PHONE # (252) 296-3406
FAX # (252) 296-3402
CELL # (252) 205-1845