

Assembly Serial # _____
Test Date / Time _____
Tester Certification # _____
Assembly Test Results <input type="checkbox"/> Pass <input type="checkbox"/> *Fail
<input type="checkbox"/> Under Suspension - Process Immediately

Cherry Creek Valley Water

Backflow Assembly Test & Maintenance Report

(please print with **BLOCK LETTERING**)

Account	Facility Name: _____		Meter #: _____			
	Facility Address: _____		City: _____			
	Contact Person: _____		Phone: _____			
Assembly	Make: _____ Model: _____		<u>Type of Use</u>			
	Type: <input type="checkbox"/> RP <input type="checkbox"/> DC <input type="checkbox"/> PVB <input type="checkbox"/> Air Gap		<u>Protection</u>			
	Size: _____ Date Installed: _____		<u>Orientation</u>			
	<input type="checkbox"/> New <input type="checkbox"/> Existing		<input type="checkbox"/> Domestic <input type="checkbox"/> Containment <input type="checkbox"/> Inlet <input type="checkbox"/> Outlet <input type="checkbox"/> Fire <input type="checkbox"/> Glycol <input type="checkbox"/> Containment by Isolation <input type="checkbox"/> Horizontal <input type="checkbox"/> <input type="checkbox"/> Irrigation <input type="checkbox"/> Isolation <input type="checkbox"/> Vertical Up <input type="checkbox"/> <input type="checkbox"/> Recycled <input type="checkbox"/> Vertical Down <input type="checkbox"/> Approved: Y <input type="checkbox"/> N <input type="checkbox"/>			
Previous Assembly #: _____						
Location: _____						
Testing & Maintenance	Line	Initial Test Results		Repairs	Re-Test Results	
	PSI:	Tightness	Differential		Tightness	Differential
	Check Valve #1 (RP, DC, PVB)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
	Check Valve #2 (RP, DC)	<input type="checkbox"/> Leak <input type="checkbox"/> Tight			<input type="checkbox"/> Leak <input type="checkbox"/> Tight	
	Relief Valve (RP)					
	Buffer (RP)					
	Air Inlet (PVB)					
	Shutoff Valve #1: <input type="checkbox"/> Tight <input type="checkbox"/> Leaking <input type="checkbox"/> Replaced		Shutoff Valve #2: <input type="checkbox"/> Tight <input type="checkbox"/> Leaking <input type="checkbox"/> Replaced			
	Backpressure: <input type="checkbox"/> Yes <input type="checkbox"/> No		Test Procedure: <input type="checkbox"/> ABPA: _____		<input type="checkbox"/> ASSE: _____	
	Comments: _____					
Notification	Alarm Company/Fire Department: _____					
	Person Notified: _____		Contacted By: _____			
	Turn Off Date/Time: _____		Turn On Date/Time: _____			
Test Kit	Test Kit Make: _____		Model: _____			
	Serial #: _____		Last Calibration Date: _____			
Tester	<i>Tester certifies this assembly has been tested with the above listed procedure and verifies the isolation valves were returned to pre-test orientation.</i>					
	Testing Company: _____					
	Tester Name: _____		Phone: _____			
	Signature: _____		Certificate Expiration Date: _____			