



BACKFLOW TEST AND MAINTENANCE REPORT FORM

*** PLEASE COMPLETE THE SWA SECTION WITH ANY INFORMATION AVAILABLE***

Name _____ Account # _____ Telephone _____
 Address _____ Contact _____
 City _____ State _____ Zip _____ Municipality _____
 Device Type _____ Serial # _____ Size _____" Test Due Date _____
 Manufacturer _____ Model # _____ Meter # _____

INSTRUCTIONS TO APPROVED TESTERS: Failure to complete this form accurately will result in rejection of the test form and possibly result in water service termination. **NO OTHER FORM WILL BE ACCEPTED**

<input type="checkbox"/> Reduced Pressure Principle Backflow Prevention Assembly (RPZ)			
<input type="checkbox"/> Double Check Valve Backflow Prevention Assembly (DC)			
Static Line Pressure: _____ PSID	Check Valve #1	Check Valve #2	Differential Pressure Relief Valve
Initial Test of Device Date _____	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight _____ PSID (RPZ)	<input type="checkbox"/> Leaked <input type="checkbox"/> Closed Tight	<input type="checkbox"/> Opened at _____ PSID <input type="checkbox"/> Did not open
Maintenance of Device (Describe Repair) Date _____	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material Used _____	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material Used _____	<input type="checkbox"/> Cleaned <input type="checkbox"/> Repaired Material Used _____
Changed or New Device Installed (must be tested on line)	<input type="checkbox"/> DC Size _____ Model _____ Serial _____ Manuf. _____	<input type="checkbox"/> RPZ Size _____ Model _____ Serial _____ Manuf. _____	
Final Test of Device Date _____	<input type="checkbox"/> Closed Tight _____ PSID (RPZ)	<input type="checkbox"/> Closed Tight	Opened at _____ PSID

REMARKS: _____

TESTER CERTIFICATION* (MUST attach a copy of your certification)

I hereby certify the above data to be correct and that the above backflow prevention assembly as in proper operating condition.

Tester (signature): _____ Test Date: _____
 Tester (print): _____ Cert. No: _____
 Company Name: _____ Telephone: _____
 Test Kit Used: _____ Date Gauge Calibrated: _____
 (Test Kit)

Please **EMAIL** the completed form to: backflow@sewickleywater.org

*Visit our website at <http://www.sewickleywater.org> for information and FAQs regarding this mandatory testing.