

ALLEN COUNTY HEALTH DEPARTMENT
BACKFLOW PREVENTION PROGRAM
 Annual Test and Maintenance Report for Backflow Prevention Assemblies

FACILITY NAME: _____

ADDRESS: _____

BACKFLOW PREVENTION ASSEMBLY INFO.	INSTALLATION INFORMATION
MAKE:	<input type="checkbox"/> WATER SERVICE
MODEL:	<input type="checkbox"/> MECH ROOM
SIZE:	PROTECTING:
SERIAL NO.	OTHER:
DATE INSTALLED: / /	

	REDUCED PRESSURE DEVICES			PRESSURE VACUUM BREAKER	
	DOUBLE CHECK DEVICES		RELIEF VALVE	AIR INLET	CHECK VALVE
	1ST CHECK	2ND CHECK			
INITIAL TEST	<input type="checkbox"/> CLOSED TIGHT RP _____ PSID <input type="checkbox"/> LEAKED	<input type="checkbox"/> CLOSED TIGHT <input type="checkbox"/> LEAKED	OPENED AT _____ PSID	OPENED AT _____ PSID <input type="checkbox"/> DID NOT OPEN	_____ PSID <input type="checkbox"/> LEAKED
REPAIRS AND MATERIALS USED					
TEST AFTER REPAIRS	<input type="checkbox"/> DC CLOSED TIGHT RP _____ PSID	<input type="checkbox"/> CLOSED TIGHT	OPENED AT _____ PSID	OPENED AT _____ PSID	_____ PSID

CERTIFICATION - TESTER: I hereby certify the above data to be correct and that the above backflow prevention assembly is in proper operation condition.

TESTER (signature) _____ TEST DATE / / _____

TESTER (print) _____ OH CERT. NO. _____

COMPANY NAME _____ PHONE NO. _____

CERTIFICATION - FACILITY: I hereby certify that the above backflow prevention assembly has been in constant use at this location during the entire prescribed interval between test periods and during that period this assembly was not bypassed, my inoperative or removed without proper authorization. All defects found during the operation period or during tests of assembly were satisfactorily corrected without delay. I further certify that I have responsibility and authority to insure the above.

OWNER/OFFICER (signature) _____ PHONE _____

OWNER/OFFICER (print) _____ DATE _____