BACKFLOW PREVENTION DEVICE TEST REPORT

Address			Facility ID:
Occupant	Emergency Contact Person		Telephone:
			Email:
Owner			Telephone:
Address of Owner			Email:
Name of Certified Tester	Tester Certification Number		Telephone:
Business Name	Business Address		Email:
Make of TEST KIT	Model Number	Serial Number	Date of Last Calibration

Device Location_____ Purpose of Device_____

Test Date _____ RP ☐ DCVA ☐ PVB ☐ SRPVB ☐

Make_____ Model _____ Serial # _____ Size _____

Initial Test ☐ Annual Test ☐ Passed ☐ Failed ☐ Line Pressure _____

REDUCED PRESSURE BACKFLOW ASSEMBLY

Check Valve No. 1
Leaked ☐ Closed Tight ☐
Pressure Differential
Across No. 1 Check _____

Check Valve No. 2
Leaked ☐ Closed Tight ☐
Pressure Differential
Across No. 2 Check_____

Relief Valve
Failed to Open
Opened at _____

Shut off valves Leaked ☐ Closed Tight ☐

Buffer (Drop across 1st check valve minus opening point of relief valve) _____

DOUBLE CHECK VALVE ASSEMBLY

Check Valve No. 1
With Flow ☐ Against Flow ☐
Leaked
With Flow ☐ Against Flow ☐
Closed Tight
Pressure Differential
Across No. 1 Check _____

Check Valve No. 2
With Flow ☐ Against Flow ☐
Leaked
With Flow ☐ Against Flow ☐
Closed Tight
Pressure Differential
Across No. 2 Check _____

PVB

Opened at _____
Failed to open ☐

Check valve: Leaked
Closed tight

Pressure Differential
Across Chk Valve ____

SRPVB

Opened at _____
Failed to open ☐

Check valve: Leaked ☐
Closed tight ☐

Check Valve Closing
Point ____

If assembly fails test, complete this section and note repairs: **(If Device replaces an existing device, list Serial # of existing device.)**

Tester Signature: _____ Date: _____

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