


Backflow Prevention Assembly Test Report

Service Address: _____ _____ _____	Control #: _____	Serial #: _____
Contact Address: _____ _____ _____	Route #: _____	Manufacturer: _____
	Meter Register #: _____	Model: _____
		Type: _____
		Size: _____
Location Description: _____ _____ _____		Orientation: _____
		Protection: _____


	Existing <input type="checkbox"/>	Commercial/Industrial <input type="checkbox"/>	Residential <input type="checkbox"/>	Construction <input type="checkbox"/>
	New <input type="checkbox"/>	Domestic <input type="checkbox"/>	Irrigation <input type="checkbox"/>	Fire <input type="checkbox"/>
	Replacement <input type="checkbox"/>	Reduced Pressure Principle Assembly		
Double Check Valve Assembly				
INITIAL TEST		# 1 Check Valve	# 2 Check Valve	Relief Valve
Pass <input type="checkbox"/>	Fail <input type="checkbox"/>	Leaked <input type="checkbox"/>	Leaked <input type="checkbox"/>	Did Not Open <input type="checkbox"/>
		Tight <input type="checkbox"/>	Tight <input type="checkbox"/>	Opened <input type="checkbox"/>
Line Pressure: _____		Held at _____ PSID	Held at _____ PSID	Opened at _____ PSID
Meter Read: _____				

INITIAL TEST	
Tester Name: _____	Gauge Serial #: _____
Tester License #: _____	Certification Date: _____
Date of Test: _____	Time of Test: _____
Signature: _____	Tester Phone #: _____

REPAIRS	Cleaned <input type="checkbox"/>	Cleaned <input type="checkbox"/>	Cleaned <input type="checkbox"/>
Date: _____	Repaired <input type="checkbox"/>	Repaired <input type="checkbox"/>	Repaired <input type="checkbox"/>
Time: _____	Parts Replaced: _____	Parts Replaced: _____	Parts Replaced: _____
Repaired By: _____			

FINAL TEST (AFTER REPAIR)	# 1 Check Valve	# 2 Check Valve	Relief Valve
Pass <input type="checkbox"/>	Leaked <input type="checkbox"/>	Leaked <input type="checkbox"/>	Did Not Open <input type="checkbox"/>
Fail <input type="checkbox"/>	Tight <input type="checkbox"/>	Tight <input type="checkbox"/>	Opened <input type="checkbox"/>
Line Pressure: _____	Held at _____ PSID	Held at _____ PSID	Opened at _____ PSID
Meter Read: _____			

FINAL TEST <input type="checkbox"/> * same as initial tester	
Tester Name: _____	Gauge Serial #: _____
Tester License #: _____	Certification Date: _____
Date of Test: _____	Time of Test: _____
Signature: _____	Tester Phone #: _____

<p>Please return completed test reports to:</p>		<p>City of Dixon Engineering Department 600 East A Street Dixon, CA 95620</p>	<p>Attn: Josh Hudson Email: jhudson@cityofdixon.us Phone: (707)678-7050x5501</p>
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