

HANCOCK PUBLIC HEALTH

Annual Test & Maintenance Report for Backflow Prevention Assemblies

Service Address: _____

Device Location: _____

Contact Person: _____ Phone: _____

Type of Device: _____

CUSTOMER: _____

Manufacturer: _____

NAME _____

Model: _____

ADDRESS _____

Serial #: _____

CITY _____

Size: _____

Owner's Certification: 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, made inoperative or removed without proper authorization. I further certify that I have the responsibility and authority to ensure the above.

Owner/Officer (printed) _____ Signature: _____

Title: _____ Tel # _____ Date: _____

TEST REPORT:

	Double Check Valve		Reduced Pressure Principle			Pressure Vacuum	
	CHECK VALVE #1	CHECK VALVE #2	CHECK VALVE #1	CHECK VALVE #2	RELIEF VALVE	AIR INLET VALVE	CHECK VALVE
Initial Test	Closed Tight: <input type="checkbox"/> Leaked: <input type="checkbox"/> _____psid	Closed Tight: <input type="checkbox"/> Leaked: <input type="checkbox"/> _____psid	Closed Tight: <input type="checkbox"/> Leaked: <input type="checkbox"/> _____psid	Closed Tight: <input type="checkbox"/> Leaked: <input type="checkbox"/>	Opened at: _____ p.s.i.d.	Opened at: _____ p.s.i.d. Did Not Open: <input type="checkbox"/>	Closed Tight At: _____ p.s.i.d. Leaked <input type="checkbox"/>
Repairs & Material Used							
Test After Repair	Closed Tight: <input type="checkbox"/>	Closed Tight: <input type="checkbox"/>	Closed Tight: <input type="checkbox"/>	Closed Tight: <input type="checkbox"/>	Opened at: _____ p.s.i.d.	Opened at: _____ p.s.i.d.	Closed Tight At: _____ p.s.i.d.

COMMENTS: IS THERE A FLOOR DRAIN NEAR BY: CIRCLE: YES NO (sump pump next to backflow device)
Disclaimer: If there is a floor drain, it may not be adequately sized, or clear of any blockage to allow for proper drainage, to handle discharge of the backflow device(s). We have not inspected the drain for blockage, or if it is properly sized to handle the backflow discharge. We have not inspected the sump pump for proper operation.

TESTER CERTIFICATION: I hereby certify that the above data is correct and that the backflow prevention device is in proper working condition.

Tester Signature: _____ OH Cert. # _____ Date: _____

Employer: _____ Address: _____

City: _____ Zip: _____ Tel # _____

Forward \$ 20. per test & test report(s) to:
 -And give a copy of test(s) to customer

HANCOCK PUBLIC HEALTH TEL # 419 – 424 - 7870
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