



Return this form to:
 Cross Connection Control Program
 650 W. Olive Avenue
 Sunnyvale, CA 94086-7637
 backflow@sunnyvale.ca.gov

Backflow Prevention Assembly Test Report

<u>Service Address</u>		Corrections _____	
Location ID _____	Serial #: _____	Manufacturer: _____	_____
<u>Mailing Address</u>	Model: _____	Type: _____	_____
Owner Name: _____	Size: _____	Orientation: _____	_____
Owner Phone: _____	Meter #: _____	<u>Location:</u> _____	
On Site Contact Name: _____	_____		
On Site Contact Phone: _____	_____		

Test Due No Later than:	Existing <input type="checkbox"/> Removed <input type="checkbox"/> New <input type="checkbox"/> Replaced <input type="checkbox"/>	<u>Hazard:</u> _____	Protection Service <input type="checkbox"/> Internal <input type="checkbox"/>
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Reduced Pressure Principle Assembly			PVB/SVB		Shutoff Valves	
Double Check Valve Assembly						
	Check Valve #1	Check Valve #2	Relief Valve	Air Inlet	Check Valve	#1 #2
Initial Test	Leaked <input type="checkbox"/> Closed Tight <input type="checkbox"/> Held at _____ PSID	Leaked <input type="checkbox"/> Closed Tight <input type="checkbox"/> Held at _____ PSID	Did not open <input type="checkbox"/> Opened at _____ PSID	Did not open <input type="checkbox"/> Opened at _____ PSID	Leaked <input type="checkbox"/> Held at _____ PSID	CLOSED TIGHT <input type="checkbox"/> <input type="checkbox"/> LEAKED <input type="checkbox"/> <input type="checkbox"/>

Repairs	
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Final Test	Closed Tight <input type="checkbox"/> Held at _____ PSID	Closed Tight <input type="checkbox"/> Held at _____ PSID	Opened at _____ PSID	Opened at _____ PSID	Held at _____ PSID	CLOSED TIGHT <input type="checkbox"/> <input type="checkbox"/>
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Comments: _____						Yes No Proper Installation <input type="checkbox"/> <input type="checkbox"/> RV Exercised <input type="checkbox"/> <input type="checkbox"/> #2 Shutoff Closed <input type="checkbox"/> <input type="checkbox"/> Service Restored <input type="checkbox"/> <input type="checkbox"/> Line Pressure _____ Meter Reading _____
I certify all information on this report is true and accurate						
Initial Test: Date _____ Time _____	Passed <input type="checkbox"/>	Failed <input type="checkbox"/>				
Signature _____	Tester _____	Certification # _____				
Test Kit Serial # _____	Test Kit Calibration Date _____					
Repairs: Date _____ Time _____						
Signature _____ Tester _____ Certification # _____						
Final Test: Date _____ Time _____						
Passed <input type="checkbox"/> Failed <input type="checkbox"/>						
Signature _____ Tester _____ Certification # _____						
Test Kit Serial # _____ Test Kit Calibration Date _____						