CITY OF ESCALON

BACKFLOW TEST REPORT

Please return report to:
Mail
CITY OF ESCALON
2060 McHenry Ave.
Escalon CA 95320

Fax:
209-691-7409

NAME OF PREMISE: _____ ☐ **Commercial** ☐ **Residential** ☐ **Fire**

SERVICE ADDRESS: _____ **CITY: ESCALON** **ZIP: 95320**

CONTACT PERSON: _____ **PHONE:** _____ **EMAIL:** _____

LOCATION OF ASSEMBLY _____

◯ **NEW INSTALLATION**
◯ **EXISTING**
◯ **REPLACEMENT**
OLD ASSEMBLY SERIAL NUMBER: _____ ___

☐ **RP** ☐ **DCVA** ☐ **DCDA**
☐ **DC** ☐ **RPBA** ☐ **RPDA**
☐ **PVB** ☐ **PVBA**

☐ **Air Gap** ☐ **SVB**

MAKE: _____ **MODEL:** _____ **SIZE:** _____ **SERIAL #:** _____

	Reduced Pressure Devices				Relief Valve *3 Lb Buffer Required*		Pressure Vacuum Breaker			
	Double Check Valves						Air Inlet		Check valve	
	1st Check		2nd Check							
Initial Test	Held @ Psi Leaked		Closed Tight Held @ Psi Leaked		Opened @ Psi Opened < 2.0 Psi or did not open		Opened @ Psi Opened < 1.0 Psi or did not open		Closed tight @ Psi Leaked	
Repairs and Materials Used	Cleaned Replaced: discs spring guide seat o-ring module Other:		Cleaned Replaced: discs spring guide seat o-ring module other:		Cleaned Exercised Replaced: discs spring diaphragm seat o-ring module other:		Cleaned Replaced: discs diaphragm FLOAT module other:		Cleaned Replaced: discs module other:	
Final Test	DC held @ Psi RP Psi		DC held @ Psi Closed Tight		Opened @ Psi		Opened @ Psi		Closed tight @ Psi	
DEVICE:	Failed		Repaired		Needs Replacing		Replaced		Passed	

REMARKS: _____

SYSTEM PRESSURE: _____

TESTER'S SIGNATURE _____ **CERT. NO.** _____ **DATE** _____

TESTER'S NAME PRINTED _____ **TESTERS PHONE #** _____

FINAL TEST BY _____ **CERT. NO.** _____ **DATE** _____