



Backflow Prevention Device Test Report Form

Submit completed form to: backflow@kingsville.ca

Facility Information

Facility Address:	Postal Code:
Business name:	
Occupant:	Phone #
Property Owner:	Phone #
Owner's Address:	Postal Code:
Contact person:	Phone #

Tester Information

Testing Company:	Phone #
Tester's name:	OWWA Cert. #
Test Kit:	Serial #
	Test Kit Calibration Date:

Device Information

Device Manufacturer:	Model #	Size:
Type of Device:	Serial #	
Device Location:		
Date of test:	<input type="checkbox"/> Passed	<input type="checkbox"/> Failed
Line pressure at time of test: _____ psi	Orientation of device: <input type="checkbox"/> Horizontal	<input type="checkbox"/> Vertical
If replacing and existing device, provide serial # of original device:		

Reduced Pressure Backflow Device

Check Valve No. 1 Pressure Differential across Check Valve No. 1 _____ psi. <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	Check Valve No. 2 Pressure Differential across Check Valve No. 2 _____ psi. <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight
Relief Valve <input type="checkbox"/> Failed to open Opened @ _____ psi Buffer _____ psi (Difference between reading @ Check valve No.1 and pressure at which relief valve opened)	
Shut off valve #1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	Shut of valve #2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight

Double Check Valve Assembly

Check Valve No. 1 Pressure drop across valve _____ psi <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	Check Valve No. 2 Pressure drop across valve _____ psi <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight
Shut Off Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	Shut Off Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight

Pressure Vacuum Breaker

Air inlet valve opened @ _____ psi. <input type="checkbox"/> Failed to open	Check valve <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight Pressure drop across valve _____ psi
Shut Off Valve No. 1 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight	Shut Off Valve No. 2 <input type="checkbox"/> Leaked <input type="checkbox"/> Closed tight

Tester's Signature: _____