



TOWN OF MEDLEY UTILITIES DEPARTMENT

CROSS-CONNECTION CONTROL

10776 NW SOUTH RIVER DRIVE MEDLEY, FL 33178

OFFICE 305-889-1915 FAX 305-889-1917 WWW.TOWNOFMEDLEY.COM

BACKFLOW PREVENTION ASSEMBLY TEST REPORT FORM

1	ADDRESS OF DEVICE:		OWNER OF DEVICE:		
	OWNER CONTACT:		PHONE::	FAX:	
	ADDRESS OF OWNER:			ZIP CODE::	
2	NAME OF TESTER:		CERTIFICATION #:	EXPIRATION DATE::	PHONE::
	BUSINESS NAME:		BUSINESS ADDRESS:		
3	TEST KIT MAKE	MODEL#	SERIAL #:	DATE LAST CAL	SITE TUBE: YES / NO

4	MAKE OF ASSEMBLY:	MODEL NO.	SERIAL #.	SIZE:
	LOCATION OF ASSEMBLY:		HAZARD/SERVICE:	METER NO.
	INITIAL TEST: _____	ANNUAL TEST: _____	DATE OF TEST:	METER READING:
	SHUT OFF VALVE #1: CLOSED TIGHT: _____ LEAKED: _____	SHUT OFF VALVE #2: CLOSED TIGHT: _____ LEAKED: _____	LINE PRESSURE: _____	PRESSURE STABLE: YES - NO

D.C.V.A.

R.P.Z.A.

P.V.B

TEST	CHECK VALVE NO. 1	CHECK VALVE NO. 2	DIFFERENTIAL RELIEF VALVE	AIR INLET	CHECKVALVE
	Closed Tight: _____	Closed Tight: _____	FAILED TO OPEN: _____	FAILED TO OPEN: _____	LEAKED: _____
	Leaked: _____	Leaked: _____		OPENED AT:	HELD AT:
	PRESSURE DIFFERENTIAL ACROSS CHECK _____ PSI	PRESSURE DIFFERENTIAL ACROSS CHECK _____ PSI	OPENED AT: _____ PSI.	_____ PSI	_____ PSI

IF THE ASSEMBLY FAILS FOR ANY REASON, COMPLETE THIS SECTION AND NOTE REPAIRS

REMARKS / REASON FOR FAILURE (if APDARENT)

REPAIRS	CHECK VALVE NO 1	CHECK VALVE NO 2	DIFFERENTIAL RELIEF VALVE	PVIS
	CLEANED: _____	CLEANED: _____	CLEANED: _____	CLEANED: _____
	REPLACED: _____	REPLACED: _____	REPLACED: _____	REPLACED: _____

UN.A.

R.P.Z.A.

P.V.B.

RETEST	CHECK VALVE NO. 1	CHECK VALVE NO 2	DIFFERENTIAL RELIEF VALVE	AIR INLET	
	Closed Tight: _____	Closed Tight: _____	FAILED TO OPEN: _____	FAILED TO OPEN: _____	LEAKED: _____
	Leaked: _____	Leaked: _____		OPENED AT:	HELD AT:
	PRESSURE DIFFERENTIAL ACROSS CHECK _____ PSI	PRESSURE DIFFERENTIAL ACROSS CHECK _____ PSI	OPENED AT: _____ PSI	_____ PSI	_____ PSI

I CERTIFY THAT I HAVE TESTED THE ABOVE ASSEMBLY IN ACCORDANCE WITH THE A W W.A. CROSS CONNECTION CONTROL MANUAL AND THAT ALL THE INFORMATION IS ACCURATE TO THE BEST OF MY ABILITIES

SIGNATURE OF CERTIFIED TESTER:	DATE:
--------------------------------	-------

FOR OFFICE USE ONLY:	DATE:
----------------------	-------