

# BACKFLOW PREVENTION TEST REPORT

**LOCATION INFORMATION:**

Service Address	Facility Name	Contact
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**DEVICE INFORMATION:**

System Contained		Source of Contamination	
Type	Make	Model	Size
Serial No.	Location		

**TEST INFORMATION:**

Line Pressure:	Reduced Pressure Assembly			Pressure Vacuum Breaker	
	Double Check Valve		Relief Valve	Air Inlet	Check Valve
	1 <sup>st</sup> Check	2 <sup>nd</sup> Check			
Initial Test	Held at _____ psid Leaked	Held at _____ psid Closed Tight Leaked	Opened at _____ psid Did not open	Opened at _____ psid Did not open	Held at _____ psid Leaked
Repair Details					
Final Test	_____ psid	_____ psid Closed Tight	Opened at _____ psid	Opened at _____ psid	Held at _____ psid

**TEST KIT INFORMATION:**

Manufacturer	Serial No.	Last Calibration Date
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**CERTIFIED TESTER INFORMATION:**

Date	Signature	Printed Name
Company Name	Phone Number	Certification No.

**COMMENTS:**

Submit test report to Pam Kirklin at Marion Utilities.  
 Fax: 765-668-8556  
 Mail: 107 E. Bond Ave., Marion, IN 46952