BACKFLOW PREVENTION DEVICE TEST REPORT

Guelph/Eramosa Township

Return completed form to: dbutton@get.on.ca

Address of BF Test:			Postal Code:
Occupant Name or Location Name	Emergency Contact Person		Telephone: Email:
Owner of testing location			Telephone:
Address of Owner (if different from test location)			Postal Code:
Name of Certified Tester	Tester Certification Number		Telephone:
Business Name	Business Address		Email:
Make of TEST KIT	Model Number	Serial Number	Date of Last test device Calibration Year/Month/Day

Device Location:	Purpose of device:		Test Date: Year/Month/Day
Type: RP ☐ DCVA ☐ PVB ☐	Serial #		Size:
Initial Test ☐ Annual Test ☐	Passed ☐	Failed ☐	Line Pressure at test time ☐ PSI

REDUCED PRESSURE BACKFLOW ASSEMBLY

Check Valve No. 1	Check Valve No. 2	Relief Valve
Leaked ☐ Closed Tight ☐	Leaked ☐ Closed Tight ☐	Failed to Open ☐
Pressure Differential Across No.1	Pressure Differential Across No.1	Opened at _____
Check _____	Check _____	
Shut off Valves Leaked ☐ Closed Tight ☐		

DOUBLE CHECK VALVE ASSEMBLY

Check Valve No. 1	Check Valve No. 2
Leaked ☐ Closed Tight ☐	Leaked ☐ Closed Tight ☐
Pressure Differential Across No.1 Check _____	Pressure Differential Across No.2 Check _____

PRESSURE VACUUM BREAKER

Opened at _____

Failed to open ☐

Check Valve:
Leaked ☐ Closed Tight ☐

Pressure Differential Across Check Valve _____

SRPVB

Opened at _____

Failed to open ☐

Check Valve:
Leaked ☐ Closed Tight ☐

Check Valve Closing Point _____

If assembly fails test, complete this section and note repairs: (**If Device replaces an existing device, list Serial # of existing device.)**

Tester Signature: Date: Year/Month/Day

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