

MUST BE COMPLETED BY THE TESTER IN INK

City of Council Bluffs
 209 Pearl St.
 Council Bluffs, IA 51503-4270
 Phone 712-328-4625
 Attn. Rodney, Backflow Department

BACKFLOW DEVICE TEST REPORT

Customer or Business Name	Contact Person	Phone Number
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Mailing Address

Service Address

Isolation Containment
 Device Protects Backflow from:

Date of Test _____ Time A.M. P.M. Supply Pressure _____ lbs

Type of Assembly	Manufacturer	Model	Size	Serial No.	Meter No.
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Height off Floor _____ (In./Ft) Protection From: Freezing Yes No Flooding Yes No

Is device installed according to plumbing code requirements? Yes No Does branch piping exist prior to the meter or containment device? Yes No

New Installation Yes No
 Plumbing Permit No. _____

Below portion must be completed by tester

DEVICE LOCATION:

REDUCED PRESSURE PRINCIPAL ASSEMBLY	Passed	Failed	REDUCED PRESSURE PRINCIPAL ASSEMBLY	Passed	Failed
Initial Test	<input type="checkbox"/>	<input type="checkbox"/>	Final Test After Repair	<input type="checkbox"/>	<input type="checkbox"/>
1st Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	1st Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
Relief Valve opened at _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	Relief Valve opened at _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
Difference (1st check-relief) _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	Difference (1st check-relief) _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
2nd Check held backpressure _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	2nd Check held backpressure _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
2nd Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	2nd Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
*Failure of any of above items requires repair					

DOUBLE CHECK VALVE ASSEMBLY	Passed	Failed	DOUBLE CHECK VALVE ASSEMBLY	Passed	Failed
Initial Test	<input type="checkbox"/>	<input type="checkbox"/>	Final Test After Repair	<input type="checkbox"/>	<input type="checkbox"/>
1st Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	1st Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
2nd Check held backpressure _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	2nd Check held backpressure _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
2nd Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>	2nd Check held in direction of flow _____ PSID	<input type="checkbox"/>	<input type="checkbox"/>
*Failure of any of above items requires repair					

PRESSURE VACUUM BREAKER	Initial Test	Air Inlet opened _____ at _____ PSID	Check Valve held in direction of flow _____ PSID	Passed	Failed
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	After Repair	Air Inlet opened _____ at _____ PSID	Check Valve held in direction of flow _____ PSID	Passed	Failed
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Repair Comments:

THE ABOVE REPORT IS CERTIFIED TO BE TRUE, ACCURATE AND COMPLETE

Tested By:	Repaired By:
Print Name _____ Signature _____	Final Test By: _____
Company _____ Tester Ph. # _____	Date: _____
Registration No _____ Registration Expiration Date: _____	