

Report on Test and Maintenance of Backflow Prevention Device

PART A	Please use a separate form for each device.	For the year _____ <input type="checkbox"/> Initial test - Complete entire form <input type="checkbox"/> Annual test - Complete Part A only
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Public Water Supply Riverhead Water District	Account No. _____	County _____	Block _____	Lot _____
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Facility Name _____ Address _____ Street _____ City _____ Zip _____	Location of Device _____ _____ _____
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Device Information	Manufacturer	Type	Model	Size (in inches)	Serial Number
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	Check Valve No. 1	Check Valve No. 2	Differential Pressure Relief Valve	Line Pressure _____ psi
Test before repair	Leaked <input type="checkbox"/> Closed tight <input type="checkbox"/>	Leaked <input type="checkbox"/> Closed tight <input type="checkbox"/>	Opened at _____ psid	Date M D Y <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Pressure drop across first check valve _____ psid			

Describe repairs and materials used				Repaired by Name _____ Lic # _____ Date repaired: _____
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Final test	Closed tight <input type="checkbox"/> Pressure drop across first check valve _____ psid	Closed tight <input type="checkbox"/>	Opened at _____ psid	Date _____
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Water Meter Number	Meter Reading	Type of Service: (check one)
_____	_____	<input type="checkbox"/> Domestic <input type="checkbox"/> Fire Other _____

Remarks (Describe deficiencies: bypasses, outlets before the device, connections between the device and point of entry, missing or inadequate airgaps, etc.)

Certification: This device _____ **MEETS** _____ **DOES NOT MEET**, the requirements of an acceptable containment device at the time of testing
 I hereby certify the foregoing data to be correct.

_____ / _____ / _____
 Print Name Certified Tester No. Signature Expiration Date

Property owner-s (or owner-s agent) certification that test was performed:

_____ () _____ - _____
 Print Name Title Signature Telephone

**** For Suffolk County Only:** Master Plumber Name: _____ Jurisdiction: Suffolk Co Consumer Affairs
 Master Plumbers Lic # _____ MP Consumer Affairs BF #: _____ BF Tester's Consumer Affairs BF #: _____

PART B Certification that installation is in accordance with the approved plans (To be completed by the design engineer or architect or water supplier.)

I hereby certify that this installation is in accordance with the approved plans

Name	Title	Date	NYS DOH Log #
_____	_____	_____	_____
License Number	Phone () _____ - _____		
_____	_____		
Representing	Describe minor installation changes		
_____	_____		
Address			

City _____ State _____ Zip _____			
Signature	_____		

NOTE: Send one completed copy to the designated health department representative and one copy to the water supplier within 30 days of the testing device. DOH-1031 (9/91) RWD
 Notify owner and water supplier immediately if device fails test and repairs cannot immediately be made.