THE CITY OF Waterloo

BACKFLOW PREVENTION DEVICE TEST REPORT

Address			Postal Code:
Occupant	Emergency Contact Person		Telephone:
			Email:
Owner			Telephone:
Address of Owner			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 Calibration

Device Location________________________ Purpose of Device____________________

Test Date____/____/________ RP ☐ DCVA ☐ PVB ☐

Make____________________ Model ______________ Serial # ________________ Size __________

Initial Test ☐ Annual Test ☐ Passed ☐ Failed ☐ Line Pressure ___________

REDUCED PRESSURE BACKFLOW ASSEMBLY

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

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

Relief Valve
☐ Failed to Open

Opened at ________
Buffer Number + 3
Buffer Total = ________
(Total should be = or Less than Diff. Valve 1)

Shut off valve No. 2 ☐ Leaked ☐ Closed Tight

DOUBLE CHECK VALVE

Check Valve No. 1

	With Flow	Against Flow
Leaked	☐	☐
Closed Tight	☐	☐

Pressure Differential
Across No. 1 Check _______

Check Valve No. 2

	With Flow	Against Flow
Leaked	☐	☐
Closed Tight	☐	☐

Pressure Differential
Across No. 2 Check ______

PRESSURE VACUUM BREAKER
Air Inlet Valve

Opened At_____ ☐ Failed to Open

Check Valve ☐ Leaked
☐ Closed Tight

Pressure Differential
Across Check Valve ______________

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

Tester Signature: ____________________________________ Date: _________________

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