

Fairview Township Sewer & Water Authorities
7485 McCray Road, PO Box 429
Fairview, PA 16415
(814) 474-2238 fax: (814) 474-3210

Cross-Connection Control Program

TEST & MAINTENANCE REPORT FOR BACK FLOW PREVENTER ASSEMBLIES

Customer Name: _____ Phone: _____
 Customer Address: _____
 City: _____ State: _____ Zip: _____
 Contact Person: _____
 Manufacturer: _____ Model: _____
 Serial #: _____ Size: _____
 Device Location: _____
 Date Installed: _____ New Installation? [] Yes [] No

Reduced Pressure Devices

| | Double Check Devices | | |
|--------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| | 1 st Check | 2 nd Check | Relief Valve |
| Initial Test | Leaked: _____ PR _____ psid Closed/Tight _____ _____ Cleaned _____ Replaced _____ Disc _____ Spring _____ Guide _____ Pin Retainer _____ Hinge Pin _____ Seat _____ Diaphragm _____ Other _____ | Leaked: _____ PR _____ psid Closed/Tight _____ _____ Cleaned _____ Replaced _____ Disc _____ Spring _____ Guide _____ Pin Retainer _____ Hinge Pin _____ Seat _____ Diaphragm _____ Other _____ | Opened at _____ psid Did not open _____ _____ Cleaned _____ Replaced _____ Disc _____ Spring _____ Guide _____ Pin Retainer _____ Hinge Pin _____ Seat _____ Diaphragm _____ Other _____ |
| Final Test | PR _____ psid Closed Tight _____ | Closed Tight _____ | Opened at _____ psid |
| | | | |

Line pressure at time of test _____ psi
 Date of Test: _____ Device Passed [] Yes [] No Device Repaired Y N
 Certified Tester: _____ Certificate #: _____
 Signature of Tester: _____
 Remarks: _____

Owner/Officer Signature: _____ Date: _____
 Owner/Officer Print: _____ Title: _____