



WOODMOOR

Water & Sanitation District No. 1

P.O. Box 1407 • Monument, Colorado 80132

BACKFLOW PREVENTION DEVICE TEST & MAINTENANCE REPORT

Owner Information

Water Supplier/Authority: _____ Meter/Account No. _____
official use only

Service Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____ Phone: _____

Owner/Mgmt. Co./Contractor: _____

Street: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Title: _____ Phone: _____

Device Information

Existing: New: Replacement For: _____

USE: Domestic: Fire: Irrigation: Isolation: Containment:

Device type: Reduced Pressure Double Check Pressure Vacuum Breaker

Manufacturer: _____ Model: _____ Size: _____ Serial No: _____

Date Installed: _____ Last Inspection/Test: _____ Main Line Pressure: _____ PSI

Location on Property: _____

Device Test & Repair Information

	Reduced Pressure Type		Double Check Type		Pressure Vacuum Breaker		Re-Test	
	Leak Tightness	Spring Tension	Leak Tightness	Spring Tension	Leak Tightness	Spring Tension	Leak Tightness	Spring Tension
Air Test						_____ PSI		_____ PSI
Check #1		_____ PSI	<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI	<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI	<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI
Check #2	<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI	<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI			<input type="checkbox"/> Tight <input type="checkbox"/> Leaked	_____ PSI
Relief Valve		_____ PSI						_____ PSI
Buffer Zone		_____ PSI						_____ PSI

Dual Check: Checks tested at min of 1.0 psi Replaced checks:

Device Mechanical Test: Pass Fail

Installation: Meets State/Local Standards Falls State/Local Standards:

Explain failure/Repairs in detail:

Person notified of any failure: _____ Title: _____

Tester & Company Information

Alarm Company/Fire Department Notified: _____

Turned off: Date: _____ Time: _____ Turned on: Date: _____ Time: _____

Tested By: _____ Cert. No. _____ Expires: _____

Company: _____ Phone: _____

Street: _____ City: _____ State: _____ Zip: _____

Test Equipment used: _____ Last Calibration Date: _____

Technician: _____ Signature _____ Date: _____ Time: _____

Device Owner or Agent _____ Signature _____ Date: _____ Time: _____