

BACKFLOW PREVENTION DEVICE TEST REPORT



To be filled out by an OWWA Cross-Connection Certified plumber registered with BSI

Address		Facility ID:
Occupant	Emergency Contact Person	Telephone:
		Email:
Owner		Telephone:
Address of Owner		Email:
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 _____ SRPVB _____

Make _____ Model _____ Serial # _____ Size _____

Initial Test _____ Annual Test _____ Passed _____ Failed _____ Line Pressure _____

REDUCED PRESSURE BACKFLOW ASSEMBLY

Check Valve No. 1 Leaked _____ Closed Tight _____	Check Valve No. 2 Leaked _____ Closed Tight _____	Relief Valve Failed to Open _____
Pressure Differential Across No. 1 Check _____	Pressure Differential Across No. 2 Check _____	Opened at _____
Shut off valves Leaked _____ Closed Tight _____	Buffer (Drop across 1 st check valve minus opening point of relief valve) _____	

DOUBLE CHECK VALVE ASSEMBLY

Check Valve No. 1 With Flow _____ Against Flow _____ Leaked _____ Closed Tight _____	Check Valve No. 2 With Flow _____ Against Flow _____ Leaked _____ Closed Tight _____
Pressure Differential Across No. 1 Check _____	Pressure Differential Across No. 2 Check _____

PVB

Opened at _____
Failed to open _____

Check valve: Leaked _____
Closed tight _____

Pressure Differential
Across Chk Valve _____

SRPVB

Opened at _____
Failed to open _____

Check valve: Leaked _____
Closed tight _____

Check Valve Closing
Point _____

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

Tester Signature: _____ Date: _____

Send cross-connection surveys to: cschwindt@woolwich.ca
backflow test must be submitted to: <https://bsionline.ca>