Town of Stanley

Po Box 279; Stanley NC 28164

704-263-4779 or 704-747-8632, Fax: 704-263- 9699

Backflow Prevention Assembly Test Form

Premises Number: _____

Location of Assembly: _____

Type:_____ Manufacturer:_____ Model:_____ Size:_____ Serial No.:_____

Name of Owner: _____

Mailing Address: _____

City, State & Zip Code: _____

Tester: _____ Certification No.: _____ Date: _____ Time: _____

Type of Service: _____ New Test ☐ Recertification Test ☐ Line Pressure: _____

Test Kit: _____ Serial No. _____ Calibration Date _____

NO. 1 CHECK VALVE	NO. 2 CHECK VAVLE	RELIEF VALVE	PRESSURE VACUUM BREAKER
☐ Leaked ☐ Closed Tight Diff Pressure Across Check Valve __.__PSID	☐ Leaked ☐ Closed Tight Diff Pressure Across Check Valve __.__PSID	Opened at ____.___ PSID	Air Inlet ____.____ PSID ☐ Did not open Check Valve ____.____PSID ☐ Leaked
☐ Cleaned ☐ Replaced:_____ _____	☐ Cleaned ☐ Replaced:_____ _____	☐ Cleaned ☐ Replaced:_____ _____	☐ Cleaned ☐ Replaced:_____
Closed Tight at ___.___PSID	Closed Tight at ___.___PSID	Opened at __.__PSID	Air Inlet ____.____PSID Check Valve ____.____PSID
Shut Off Valve #1 _____ Leaked _____ Closed Tight		Buffer: _____	Shut Off Valve #2 _____ Leaked _____ Closed Tight

Comments: _____

_____

This Assembly: _____PASSED _____ FAILED

I hereby certify that this data is accurate and reflects the proper operation and maintenance of the assembly.

_____
(Signature of Licensed Tester and Date)

*All Repairs must be made within 10 Business Days