CITY OF DUQUESNE
WATER DEPARTMENT
12 S SECOND STREET
DUQUESNE, PA 15110
412-466-8535 Fax 412-346-0289

CROSS-CONNECTION CONTROL DEVICE

TESTING RESULTS

I,_____, have tested the Double Check Valve Backflow Preventer at:

NAME _____

ADDRESS _____

( ) In good working order

( ) Inoperable. (State what needs to be done to the device, i.e., repaired/replaced)

_____

_____

_____

_____

_____

SIGNATURE_____

DATE_____

TEST and MAINTENANCE REPORT FORM
RPZ – REDUCED PRESSURE ZONE ASSEMBLY – RPZ

PLEASE COMPLETE THE FOLLOWING:

NAME:

DUE DATE:
ACCOUNT #:

DEVICE TYPE:
MANUFACTURER:

WATER METER:
SERIAL#:
MODEL#
SIZE:

INSTRUCTIONS TO APPROVED TESTERS: All applicable information must by typed or clearly printed. Please use "Y" or "N" to respond to YES or NO questions. Failure to complete this form accurately will result in rejection of the test form and possibly result in water service termination. PLEASE ATTACH A COPY OF YOUR CERTIFICATION.

INITIAL TEST OF DEVICE

Check Valve #1 Tight_____ PSID

Check Valve #2 Closed Tight: _____ Leaked: _____

Differential PRV Opened At: _____ PSID Did Not Open _____

Passed: _____ Tester: _____ Certificate: _____

Date: ____/____/____ Remarks: _____

MAINTENANCE OF DEVICE

Check Valve #1 Cleaned_____ Repaired_____

Check Valve #2 Cleaned_____ Repaired_____

Differential PRV Cleaned_____ Repaired_____

Repairs: _____

Date: ____/____/____ Repaired by: _____

CHANGED or NEW DEVICE INSTALL (must be tested on line)

Date:____/____/____ Device Type:_____ Serial_____

Assembly_____ Size_____ Manufacturer_____ Model_____

Installed by_____ Remarks_____

FINAL TEST OF DEVICE (must be completed)

#1 Tight: _____ PSID #2 Closed Tight:_____ Differential PRV Opened at_____ PSID

Passed:_____ Tester:_____ Certificate:_____

Date:____/____/____ Remarks:_____

Additional Comments:_____

The above report is certified true.

_____
Signature of approved tester

_____
Print name as above

PLEASE RETURN TO:

CITY OF DUQUESNE
12 SOUTH SECOND STREET
DUQUESNE, PA. 15110
412-466-8535 fax 412-346-0289